

AUG 18 1936

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25924

1. PLACE OF DEATH

County, Clark
Township, Des Moines
City, Wayland

Registration District No. 193
Primary Registration District No. 4116

File No. _____
Registered No. _____
St. _____ Ward)

2. FULL NAME

Elizabeth Joseph

(a) Residence No. _____ St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Anthony F. Joseph

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2, 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 5 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Clark Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Dr. S. J. M. Force

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Frankford
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Judith P. Mitchell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)

14. INFORMANT Miss Ora J. Davis
(Address) Wayland, Mo.

15. FILED 7/15, 1936 H. F. Kircher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 14, 1936

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1936, to July 14, 1936
that I last saw him alive on July 14, 1936, and that death occurred, on the date stated above, at 4:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY Paralysis, General
(SECONDARY) (duration) _____ yrs. _____ mos. 14 da.

18. WHERE WAS DISEASE CONTRACTED Mo.
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) A. J. Johnson, M. D.

(Address) Wayland Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mitchell Cemetery DATE OF BURIAL 7/16 1936

20. UNDERTAKER H. F. Kircher ADDRESS Wayland Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

