

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

Do not use this space.

707

1. PLACE OF DEATH

County Blair
Township Liberty
City Liberty

Registration District No. 201
Primary Registration District No. 3012

File No. _____
Registered No. 6
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

1849

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ____ hrs. or ____ min.

80

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Ray Lester Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Wayman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Elta Mae Heston

14.

INFORMANT
(Address)

Elta Mae Heston
Liberty Mo.

15.

FILED

4/10/29

Wm H. Goodson

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

Jan 30 1929

17.

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 30, 1929, that I last saw her alive on Jan 30, 1929, and that death occurred, on the date stated above, at 1:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral arteriosclerosis
97
4113
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Chilling one night when left alone
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) Wm H. Goodson, M. D.
4/10/29, 19 (Address)

*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

DATE OF BURIAL

Farmville, Liberty Mo.

2/1/29

20. UNDERTAKER

ADDRESS

Church - Larch Co., Liberty, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

2-1-1929
24
55
4

234

1

1

31

