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.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 30725

or

Village ..... Primary Registration District No. 1003 Registered No. 8630

or

City ..... (NO. 1515 Hebert St.; V Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Susan Ellis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: May (Month) 22 (Day), 1839 (Year)

7 AGE: 79 yrs. 3 mos. 21 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (City or town, State or foreign country): England

PARENTS

10 NAME OF FATHER: George Nye

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Cox

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr John Sternecker Daughter

(Address) 1515 Hebert St

15 Filed Max C Starkloff Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 12 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept. 7, 1918, to Sept 12, 1918, that I last saw her alive on Sept. 12, 1918, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. L. Carriere M. D.

9/13, 1918 (Address) 2128 St Louis Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Bellefontaine Cemetery

DATE OF BURIAL: Sept 15, 1918

20 UNDERTAKER: [illegible]

ADDRESS: 3661 Washington

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

**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.

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... 1..... (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., .....
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ....., 191..... |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| | |