LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

2043-a

Gronoway

2043

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

1 PLACE OF DEATH

County Macon

Township ~~Calfac~~ or ~~Chariton~~

Village Nerrows or City ..... (NO. ..... St.; ..... Ward)

Registration District No. 535 File No. 6

Primary Registration District No: 5729 Registered No. 6

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

2 FULL NAME Elizabeth S. Blankenship

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

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

6 DATE OF BIRTH May 27 (Month) (Day) 840 (Year)

7 AGE 78 yrs. 8 mos. 3 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country) Macon Co Mo

PARENTS

10 NAME OF FATHER Geo Leter

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

12 MAIDEN NAME OF MOTHER Amelia Grimes

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ~~McL~~ J Geo Leter

(Address) Ardmore Mo

15 Filed Mch 4, 1920 J A Reyl Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 20 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 30, 1919, to Jan 20, 1920, that I last saw her alive on Jan 20, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

97 Cerebral arterio Sclerosis

(Duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) 81

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

(Signed) J. P. Gronoway M. D.

Jan 22, 1920 (Address) Bevier Mo

*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 Antioch Cemetery

DATE OF BURIAL Jan 22, 1920

20 UNDERTAKER Albert Skinner

ADDRESS Macon 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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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 .....

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.

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (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

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