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 McDonald

Township Elk River
or
Village Noel
or
City ..... (No. ..... St. ..... Ward)

Registration District No. 1149 File No. 19886 F

Primary Registration District No. 1696 Registered No. .....

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

2 FULL NAME Zena Bixby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct 13 1891 (Month) (Day) (Year)

7 AGE: 28 yrs. 7 mos. 18 ds.

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

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

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

PARENTS

10 NAME OF FATHER: John B. Bixby

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

12 MAIDEN NAME OF MOTHER: Jennie A. Clark

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie A. Pulse
(Address) Noel Mo

15 Filed June 1, 1911 A. J. Yates Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 31 (Day), 1930 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 30, 1930, to May 31, 1930, that I last saw her alive on May 31, 1930, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:
(a) Obstruction of the Bowels
(b) Stercoral Vomiting all
(c) of this time
(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): Suppression of Urine
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) B. F. Rogers M. D.
June 7, 1930 (Address) Noel 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. 6 mos. ..... ds. In the State ..... yrs. [illegible] mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence: Diller Neb

19 PLACE OF BURIAL OR REMOVAL: Diller Neb
DATE OF BURIAL: June 3 1930

20 UNDERTAKER: Haggoner Bros
ADDRESS: Diller Neb

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 .....

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.....

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

.....

20 UNDERTAKER

ADDRESS