LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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: Shelby

Township: ... or

Village: Shelbyville or

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

Registration District No. 831 — File No. 7270a

Primary Registration District No. 4504 — Registered No. 4

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

2 FULL NAME Eliza Griffith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Mar. 4 (Month) 1848 (Day) (Year)

7 AGE: 73 yrs. 10 mos. 27 ds. — If LESS than 1 day, ... hrs. or ... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Clayton, Ill.

PARENTS

10 NAME OF FATHER: Jacob Hiles

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

12 MAIDEN NAME OF MOTHER: Mary Haley

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Griffith
(Address) Shelbyville, Mo.

15 Filed June 4, 1922 Hallie Bidgood, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. 3 (Month) Feb. 2 (Day) 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec. 20, 1921, to Feb. 2, 1922, that I last saw her alive on Feb. 1, 1922, and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:
1B Mitral regurgitation
2 Edema of lungs

(Duration) ... yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary): chronic nephritis

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

(Signed) S. O. Mainprice M. D.
Feb. 7, 1922 (Address) Shelbyville 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: Shoot Creek — DATE OF BURIAL: Feb. 3, 1922

20 UNDERTAKER: J. W. Crumpton Bros. — ADDRESS: Shelbyville, Mo.

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