

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

Do not use this space.

35030

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **19005**

City.....

St. Ward)

2. FULL NAME

Elizabeth Elliston

(a) Residence. No. **2416 N Spring St.** **11** Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred hrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 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) **Mar 15-27**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	1	6	26	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) **Christopher Ill.**
(STATE OR COUNTRY) **Illinois**

10. NAME OF FATHER **Louis Elliston**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Illinois**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Camelia Krbin**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Kamas**
(STATE OR COUNTRY)

14. INFORMANT **Louis Elliston**
(Address) **2416 N Spring av**

15. FILED **OCT 11 1928** **Max B. Starckoff**
19. _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** **Oct 11** 19 **28**

17. I HEREBY CERTIFY That I attended deceased from **Sep 20** 19 **28** to **Oct 11** 19 **28** that I last saw her alive on **Oct 11** 19 **28**, and that death occurred, on the date stated above, at **12:30 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

4 Pertussis
107A (duration) _____ yrs. _____ mos. **10** da.
CONTRIBUTORY **Broncho-pneumonia**
(SECONDARY) **Secondary** (duration) _____ yrs. _____ mos. **4** da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH. **No** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical examination**
(Signed) **John P. Roberts**, M. D.
, 19 (Address) **2945 Bankli.**

*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 **To Christopher Ill.** DATE OF BURIAL **Oct 12 1928**

20. UNDERTAKER **Cullinane Bros** ADDRESS **7104 Grand**

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.

O.K.
10/20/21