

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

Do not use this space.

40697
5102

1. PLACE OF DEATH

County Jackson Registration District No. 533
Township Haw Primary Registration District No. Harrison
City Harrison City (No. 5334) St. _____ Ward _____

2. FULL NAME

Avarella Eldridge Ovinge
(a) Residence. No. 5334 Harrison St., 6 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 8, 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 4 30

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

10. NAME OF FATHER

Daniel B. Eldridge

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER

Anna M. Lovett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

14.

INFORMANT Fred H. Ovinge
(Address) 3534 Harrison

15.

FILED 17 11 29 M. M. Ovinge
REGISTRAR Ans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1929, to Dec 11th, 1929 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 6:40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

108 115 Lobar Pneumonia
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Acute pharyngitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

Signed Chas. H. Washington, M. D.

17/11, 1929 (Address) 1325 Piatt Bldg

*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 DATE OF BURIAL

2nd Monach Dec 14 1929

20. UNDERTAKER ADDRESS
S. H. Newcomer's Sons K6 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.

1325 Kalls Alley.

M. 1145

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