

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

Do not use this space.

1. PLACE OF DEATH

County Butler
Township
City Neelyville (No. _____)

Registration District No. 88
Primary Registration District No. 4054

File No. 19023
Registered No. 19
St. _____ Ward _____

2. FULL NAME Edith Elda S Herrell

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>L</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 4 - 1933</u>			
7. AGE	YEARS	MONTHS	DAYS
			If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.			

9. BIRTHPLACE (CITY OR TOWN) Neelyville
(STATE OR COUNTRY) Mo

PARENTS	10. NAME OF FATHER <u>Rosa S Herrell</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Neelyville</u> (STATE OR COUNTRY) <u>Mo</u>
	12. MAIDEN NAME OF MOTHER <u>Edith Elda Myers</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Leavenworth</u> (STATE OR COUNTRY) <u>Kansas</u>

14. INFORMANT Rosa S Herrell
(Address) Neelyville Mo

15. FILED 7-5-33 R. L. Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1933

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ Alive on _____, 19____, and that death occurred, on the date stated above, at _____, 3:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

no medical treatment
no cause of death
embossion
(duration) _____ yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 20010
(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) _____, M. D.

_____, 19____ (Address) _____

*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 Coon Island Cemetery DATE OF BURIAL June 4 1933

20. UNDERTAKER Friends and Neighbors ADDRESS _____

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.

JUL 20 1933

