

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

Do not use this space.

11523

APR 25 1934

1. PLACE OF DEATH

County Saline
Township
City Marshall (No. _____)

Registration District No. 796
Primary Registration District No. 3038

File No. _____
Registered No. 30 St. _____ Ward _____

2. FULL NAME

Eliza Ann Roeder
(a) Residence, No. 229 E. College 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 19-1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 7 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ✓

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co Mo.

13. NAME Joe Holloway

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dad

15. MAIDEN NAME Ellie Chapman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dad

17. INFORMANT C. M. Roeder (ADDRESS) Marshall Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE High Grove DATE Feb 28 1934

19. UNDERTAKER W. H. Campbell (ADDRESS) Marshall Mo

20. FILED 8/27 1934 W. H. Campbell Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 1934

22. I HEREBY CERTIFY, That I attended deceased from Mar. 26 1934 to Mar 27 1934

I last saw h^er alive on Mar 27 1934 Death is said to have occurred on the date stated above, at 2 P.M.

The principal cause of death and related causes of importance were as follows:

Pneumonia (Bacterial) Date of onset 3-24-34

Asphyxia 8-15

Asphyxia 8-15

Other contributory causes of importance: Amiplegia 1-10 3-27-34

Name of operation _____ Date of _____

What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

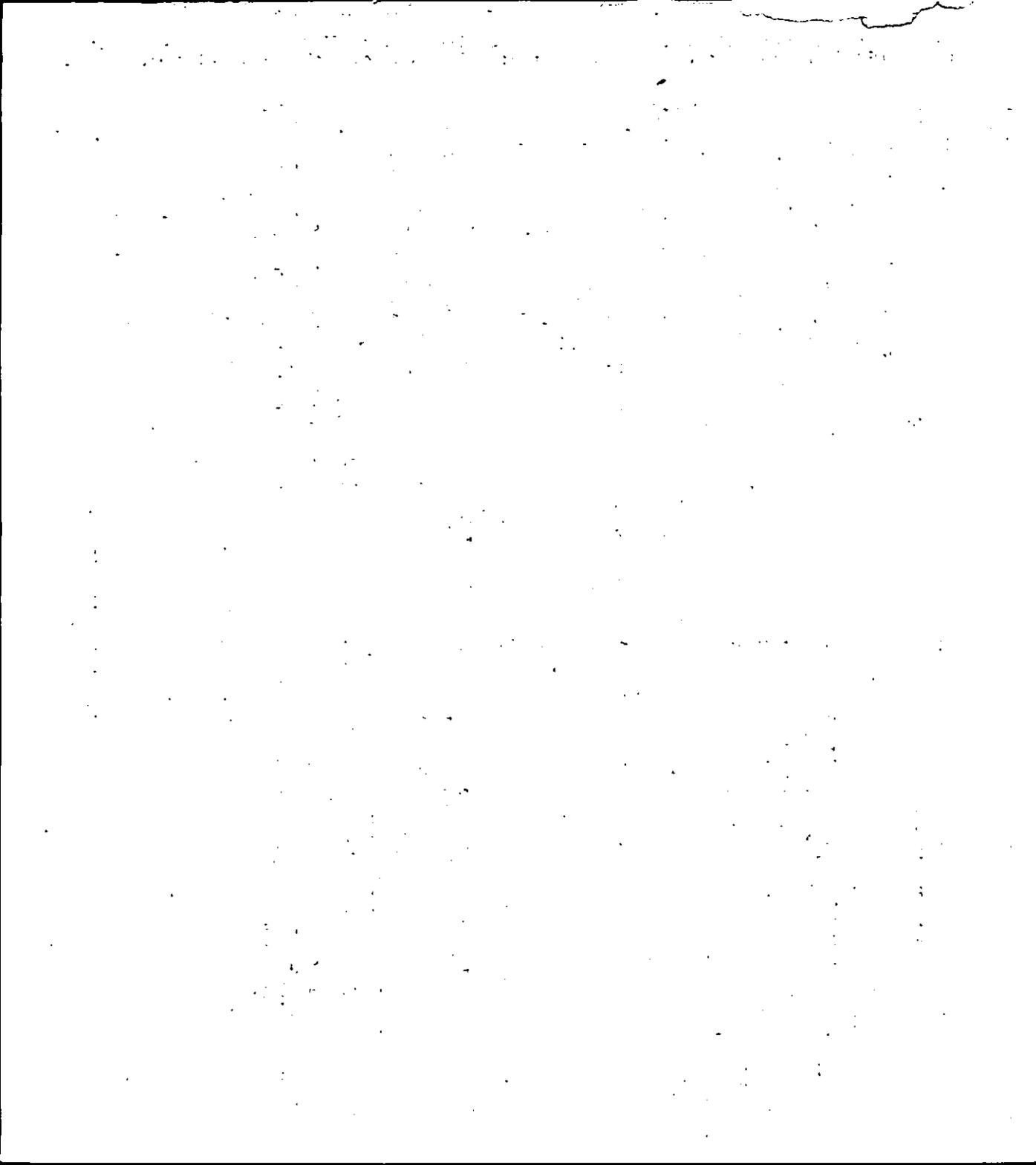
If so, specify _____

(Signed) A. Putnam M. D.

(Address) Marshall Mo.

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.



Saline

WASHINGTON

50

11523

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Eliza Ann Bowler
Who died at _____ on Mar 27-1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: wid

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Hemiplegia *gpa*

Other contributory causes of importance Cerebral Hemorrhage

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar E. T. McGaugh Date filed 3/27/34 10/5/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 796

E. T. McGaugh

State Registrar

Special Agent.

Primary Reg. Dist. No. 3038

