

MAY 25 1934

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

Do not use this space.

13302

1. PLACE OF DEATH

County Jasper Registration District No. 412
Township Osborn Primary Registration District No. 3370
City Jasper (No. 2) St. Jasper Ward 29

2. FULL NAME

Elizabeth Sullivan
(a) Residence, No. Osborn Ward. 11th
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 26 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
73 10 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) Osborn, Mo.

13. NAME Elizabeth Kelly

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jasper, Mo.

15. MAIDEN NAME Catherine Hart

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jasper, Mo.

17. INFORMANT Wm. J. Mason (ADDRESS) Osborn, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Osborn Cem. DATE Apr 11 1934

19. UNDERTAKER Frank Sullivan (ADDRESS) Jasper, Mo.

20. FILED 4/11/34 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 10, 1934

22. I HEREBY CERTIFY, That I attended deceased from 1934, 1934, to Apr 10, 1934

I last saw her alive on Mar 26, 1934 Death is said to have occurred on the date stated above, at 100 m.

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

Pulmonary Asphyxia
due to failure of
right heart
Date of onset 11/5

Other contributory causes of importance:

Name of operation _____ Date of _____

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1934

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? _____

If so, specify _____

(Signed) W. J. Mason, M. D.

(Address) Osborn, 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.

JAN 15 1935

Gasper

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 Jane Sullivan
Who died at _____ on April 10 - 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: _____

Date of birth _____ Age: Years 73 Months 10 Days 14

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) St. Louis
Birthplace of father (State or country) Illinois
Birthplace of mother (State or country) Illinois
Principal cause of death: Pulmonary edema - due to failure of heart

Other contributory causes of importance _____
Name of operation _____ Date of _____ 93d1

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 W. J. Hagan
Address of physician _____

Signature of Registrar _____ Date filed _____

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. 412
Primary Reg. Dist. No. 5570

E. T. McCaugh
State Registrar

Special Agent.

no more information available

S-13302