LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

1 PLACE OF DEATH

County Marion

Township Warren or Village or City (NO. St.; Ward)

Registration District No. 552

Primary Registration District No. 5745

File No. 10077a

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sariah J. McElroy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Aug (Month) 11 (Day) 1849 (Year)

7 AGE: 71 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country): Shelby Co Mo

10 NAME OF FATHER: Wm C Mitchell

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Va

12 MAIDEN NAME OF MOTHER: Alice T Bell

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W C McElroy

(Address) Emden Mo

Filed Apr 16 1921 Mrs Lee Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr (Month) 14 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb - 26 1921, to Apr 14 1921, that I last saw her alive on Apr 14 1921 and that death occurred, on the date stated above, at 8:15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis Bronchial Pneumonia of 20 days

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pleurisy with Effusion (Duration) ....yrs. 1 mos. about 40 ds.

(Signed) Gregory Delaney M. D.

Apr 15 1921 (Address) Emden

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Andrew Chappel

DATE OF BURIAL: Apr. 17 1921

20 UNDERTAKER: J.W. Thompson & Co

ADDRESS: Hunnewell Mo.

LOCAL | NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County ....

Township .... or Village .... or City .... (NO.........., ...St., ...Ward)

Registration District No. ....

Primary Registration District No. ....

File No. ....

Registered No. ....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME ....

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX	16 DATE OF DEATH .... (Month) .... (Day) 191.... (Year)
4 COLOR OR RACE	
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)	
6 DATE OF BIRTH .... (Month) .... (Day) , 1.... (Year)	17 I HEREBY CERTIFY, that I attended deceased from ...., 191...., to ...., 191...., that I last saw h.... alive on ...., 191...., and that death occurred, on the date stated above, at ....m.
7 AGE ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ......min.?	The CAUSE OF DEATH* was as follows:
8 OCCUPATION (a) Trade, profession, or particular kind of work	....
(b) General nature of industry business, or establishment in which employed (or employer)	.... (Duration) ....yrs. ....mos. ....ds.
9 BIRTHPLACE (City or town, State or foreign country)	CONTRIBUTORY (Secondary) .... (Duration) ....yrs. ....mos. ....ds.
PARENTS 10 NAME OF FATHER	(Signed) .... M. D.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	.........., 191.... (Address) ....
12 MAIDEN NAME OF MOTHER	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	Where was disease contracted if not at place of death? ....
(Informant)	Former or usual residence ....
(Address)	19 PLACE OF BURIAL OR REMOVAL .... DATE OF BURIAL ...., 191....
15 Filed ...., 191...., ... Registrar	20 UNDERTAKER .... ADDRESS ....