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

Do not use this space.

22204

File No.

Registered No. 62

1. PLACE OF DEATH
County Carroll
Township
City Carrollton (No. 206 West Heidel St., 3rd Ward)
Registration District No. 135
Primary Registration District No. 3914

2. FULL NAME Elizabeth Stickel Brewer

(a) Residence. No. 206 W Heidel St., 3rd Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
~~HUSBAND OF~~ (OR) WIFE OF E B. Brewer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-1-1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	74	11	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Duquoin Ill
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Moses Stickel
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Elizabeth Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ill

14. INFORMANT E B Brewer
(Address) Carrollton Mo

15. FILED 7-3, 1930 Mrs E E Trimbam REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-2 1930

17. I HEREBY CERTIFY, That I attended deceased from 4/1/30 to 6/2/30, 19..., that I last saw h.e alive on 7/1, 1930 and that death occurred, on the date stated above, at 7:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

I Pneumonia
Hypostatic
She fell - accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fracture left femur

(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

D DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) William G. Atwood M. D.

7/2, 1930 (Address) Carrollton Mo

*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 Oakdell Cemetery

DATE OF BURIAL 7/3 1930

20. UNDERTAKER Wells Funeral Home

ADDRESS Carrollton Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Carroll — Registration District No. 135 — File No. 22204
Township — Primary Registration District No. 3010 — Registered No.
City Carrollton (No. ..., ..., St. ..., Ward)

2. FULL NAME Elizabeth Stickel Brewer

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

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

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

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
(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED July 8, 1930 — Mrs. E. E. Farmer — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 2 19 30

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 ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Hypostatic Pneumonia, accidental
fall She had been
sick + got up + went
to the kitchen + in her
(DURATION) ... yrs. ... mos. ... ds.
CONTRIBUTORY Fracture left femur
(SECONDARY) weakened condition she
(DURATION) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED Lost her balance
IF NOT AT PLACE OF DEATH? + fell with the
DID AN OPERATION PRECEDE DEATH? ... DATE OF ... above result

WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ..., M. D
..., 19 (Address)

*State the DISEASES 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 ... 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

1-25-31

S-22204