

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

Do not use this space.

1. PLACE OF DEATH

County Ray
Township Green
City Lawson

Registration District No. 742
Primary Registration District No. 5977a

File No. 15348
Registered No. 8
St. _____ Ward _____

2. FULL NAME

Mrs Elizabeth Gates

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR ~~DECEASED~~ (use in the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. C. Yates

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 3 26

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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) Mo.

PARENTS

10. NAME OF FATHER A. J. Hill

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

12. MAIDEN NAME OF MOTHER Mary Logan

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

14. INFORMANT C. C. Yates (Address) Lawson Mo

15. FILED 4/28/31 1931 E. D. Brown REGISTRAR (Address) Edwin's House

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 27 19 31

17. I HEREBY CERTIFY That I attended deceased from _____ 1931 to _____ 1931 that I last saw him _____ alive on _____ 1931, and that death occurred, on the date stated above, at _____ 1145 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Adeno Sarcoma of uterus & ovaries
Operated on Jan - 1931 - could remove all extended disease
(duration) _____ yrs. _____ mos.

CONTRIBUTORY (SECONDARY) 48 (duration) _____ yrs. _____ mos. _____ da.

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

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF _____ 1st Feb 1931
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & lab
(Signed) E. D. Brown M. D.
(Address) Exp. Spgs 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 Lawson Mo DATE OF BURIAL Apr 27 19 31

20. UNDERTAKER E. M. Ward ADDRESS Lawson 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.

MAY 27 1931

