Form U. S. C.—

PLACE OF DEATH

County of *Fayette*

Township of *Oelwein*

City or Town of *Oelwein* (No. *622 - 2nd Ave* St.; *3* Ward)

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

Registered No. *27* 33 248

FULL NAME *Elizabeth Crogan*

IOWA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

SEX: *Female*

COLOR: *White*

DATE OF BIRTH: *Aug* (Month) *15* (Day) *1850* (Year)

AGE: *75* years ..... months ..... days

SINGLE, MARRIED, WIDOWED OR DIVORCED: *Widow*

BIRTHPLACE (State or country): *Ireland*

NAME OF FATHER: *Samuel Lynch*

BIRTHPLACE OF FATHER (State or country): *Ireland*

MAIDEN NAME OF MOTHER: *Elizabeth Mulligan*

BIRTHPLACE OF MOTHER (State or country): *Ireland*

OCCUPATION: *House Wife*

THE ABOVE STATED PERSONAL PARTICULARS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Informant) *Mrs Jas Donahue*

(Address) *Oelwein Ia*

(Over)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: *January* (Month) *8th Thursday* (Day) *1925* (Year)

I HEREBY CERTIFY, That I attended deceased from *[illegible]* 19*[illegible]* to *Jan 8th* 19*25*

that I last saw h*er* alive on *Jan 8th* 19*25*

and that death occurred, on the date stated above, at *3* *P*. M. The CAUSE OF DEATH was as follows:

Valvular disease of Heart

(DURATION) *[illegible] years*

Contributory ..... (DURATION) ..... days

(Signed) *Chas. B. Hazlewood* M. D.

..... 19..... (Address) .....

SPECIAL INFORMATION only for Hospitals, Institutions, Transients or Recent Residents.

Former or Usual Residence ..... How long at Place of Death? ..... Days

Where was disease contracted, if not at place of death? .....

PLACE OF BURIAL OR REMOVAL: *Oelwein*

DATE OF BURIAL: *Jan 10* 1925

UNDERTAKER: *Ross & Son* License *222*

ADDRESS: *Oelwein*