

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

PLACE OF DEATH

County Webster

Township Grant

or  
Village \_\_\_\_\_

or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 896

File No. 4001

Primary Registration District No. 6199

Registered No. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Laura J. Trantham

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>Jan 6, 1913</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Oct 2, 1882</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Dec 26, 1912, to Jan 6, 1913,</u> that I last saw her alive on <u>Jan 6, 1913,</u> and that death occurred, on the date stated above, at <u>8 P. m.</u>	
AGE <u>30</u> yrs. <u>3</u> mos. <u>4</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>1. Grippe</u> <u>11 B</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u>			(Duration) ___ yrs. ___ mos. <u>21</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Mo 9-10</u>			Contributory <u>Dysphoid fever</u> (SECONDARY) (Duration) ___ yrs. ___ mos. <u>14</u> ds.	
PARENTS	NAME OF FATHER <u>M. W. Basley</u>		(Signed) <u>W. C. Sumner</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>		<u>Jan 7, 1913</u> (Address) <u>Stafford Mo</u>	
	MAIDEN NAME OF MOTHER <u>D. L. Lindley</u>		*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>B. B. Granger</u> (ADDRESS) <u>Stafford Mo</u>			Where was disease contracted if not at place of death? Former or usual residence _____	
Filed <u>Jan 10, 1913</u> <u>W. Beatie</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>at P. P. Cemetery</u> DATE OF BURIAL <u>Jan 7, 1913</u> UNDERTAKER <u>G. B. Beckwith</u> ADDRESS <u>Harrison</u>	

