

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

PLACE OF DEATH

County Linn

Township Linn

Village Lakrange

City Lakrange (NO. _____ St. _____ Ward _____)

Registration District No. 480

Primary Registration District No. 4289

File No. 13061

Registered No. 10

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

FULL NAME Pauline Newman

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Colored SINGLE MARRIED WIDOWED OR DIVORCED unmarried
(Write the word)

DATE OF BIRTH Don't know
(Month) (Day) (Year)

AGE Don't know If LESS than 1 day, ___ hrs. or ___ min.?
yrs. mos. ds.

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Linn Co Mo

NAME OF FATHER John Bras

BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know

MAIDEN NAME OF MOTHER Don't know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Turpin

(ADDRESS) Lakrange Mo

Filed 4/27 1914 W. J. F. F. F. F. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 26th 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 27, 1914, to April 20th, 1914, that I last saw h. ce alive on April 20th, 1914, and that death occurred, on the date stated above, at 7⁴, m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Disease of the Heart

19 (Duration) 506 yrs. ___ mos. ___ ds.

Contributory Secondary
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. O. Owens M. D.
April 27 1914 (Address) Lakrange Mo

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

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 _____

PLACE OF BURIAL OR REMOVAL Lakrange Mo DATE OF BURIAL April 27 1914

UNDERTAKER Wash & Sanders ADDRESS Lakrange Mo

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.

