MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

**PLACE OF DEATH**

County: Maul Gamy

Township: Blue Creek — Registration District No.: 596 — File No.: 2560

or Village: — Primary Registration District No.: 5787 — Registered No.:

or City: ~~Bellflower~~ (No. ..... St. ..... Ward)

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

**FULL NAME** Laura Virginia Brooks

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Female | White | Married |

DATE OF BIRTH: October 26, 1873 (Month) (Day) (Year)

AGE: 42 yrs. 3 mos. 2 ds. — If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

BIRTHPLACE (City or town, State or foreign country): Warren Co. Mo.

PARENTS
NAME OF FATHER: Wm Burks
BIRTHPLACE OF FATHER (City or town, State or foreign country): Maul Gamy Co Mo
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Brooks

(ADDRESS) Bellflower, Mo.

Filed ~~Feb 7~~ Jan 31 1916 J. A. Bellamy REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: June (Month) 28 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 24, 1916, to Jan 25, 1916, that I last saw her alive on Jan 28, 1916, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Heart Clot - Pericardial being carried up from Intestinal vessels
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Child Birth. Placenta Previa (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Bellamy M. D.
Jan 29, 1916 (Address) Bellflower 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: Bellflower Cemetery — DATE OF BURIAL: 1-30 1916

UNDERTAKER: Chas Murphy — ADDRESS: Bellflower Mo

# Revised United States Standard Certificate of Death

**MISSOURI STATE BOARD OF H**
**BUREAU OF VITAL STATISTIC**
**CERTIFICATE OF DEATH**

**PLACE OF DEATH**

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ St.; _____ Ward) [If death hospital o give its R of street ar

**FULL NAME** _____

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH _____ (Month) _____ (Day), *I* _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day)

I HEREBY CERTIFY, that I attended decea _____, 191__, to _____ that I last saw h_____ alive on _____ and that death occurred, on the date stated above, at_____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____

_____, 191__ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANS RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

| PLACE OF BURIAL OR REMOVAL | DATE OF BURI |
|---|---|
| | |
| UNDERTAKER | ADDRESS |