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

8294

1 PLACE OF DEATH

County Stone

Township ~~Pierce~~ or Village or City Crane

Registration District No. 842 File No.

Primary Registration District No. 4512 Registered No.

(NO. St.; Ward)

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

2 FULL NAME Luthena Jane Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: Oct (Month) 10 (Day), 1860 (Year)

7 AGE: 58 yrs. 3 mos. 22 ds.

If LESS than 1 day, ...hrs. or ....min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Lawrence Co Mo

PARENTS

10 NAME OF FATHER: Binion

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

12 MAIDEN NAME OF MOTHER: Smith

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C H Wheeler

(Address) Crane Mo

15 Filed 2-9-, 1919. R W Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 2 Feb (Month) 3 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 25, 1919, to 2-2, 1919

that I last saw her alive on 2-2, 1919

and that death occurred, on the date stated above, at 4300 m.

The CAUSE OF DEATH* was as follows:

Influenza

11B

10

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

8 (Duration) ....yrs. ....mos. ....ds.

(Signed) J C R Dozgett M. D.

2-4, 1919 (Address) Crane Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Osa Mo

DATE OF BURIAL: Feb 3, 1919

20 UNDERTAKER: W E Hilton

ADDRESS: Crane

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

1 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 occurr
hospital or insti
give its NAME
of street and nur

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs..... mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191..
(Month) (Day) (

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 191

that I last saw h.....alive on ....., 191

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) .....M

....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie or 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.
20 UNDERTAKER	ADDRESS