

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

Do not use this space.

14139

1. PLACE OF DEATH

County Wells
Township Rockville
City Rockville (No. _____)

Registration District No. 54
Primary Registration District No. 40.2.2

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Lula Belle Bain

(a) Residence. No. _____ St., _____ Ward, _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | white | Married

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF

Amace Bain

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-29-1891

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 | 11 | 17 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Rockville
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Samuel Sanson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Emma Henry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

14. INFORMANT Mrs Grace Archer
(Address) Rockville Missouri

15. FILED May 19 1927 Wells Rockville
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May, 17, 1927, 19

17. I HEREBY CERTIFY, That I attended deceased from not at all all, 19, to 19, that I last saw h. O.T. alive on May, 17, 1927, 19, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis.

2.3A
31 several years (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) A. B. Freeman, M. D.

, 19 (Address) Rockville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Rockville Cemetery DATE OF BURIAL May 18 1927

20. UNDERTAKER S. B. Bothwell ADDRESS Rockville Mo.

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.

JUN 24 1927

1948

1949

1950

1951

1952

1953