

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

Do not use this space.

✓ 15909

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.

PLACE OF DEATH

County Missouri Registration District No. 601 File No. _____
 Township Little Prairie Primary Registration District No. 9-862 Registered No. 60
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Lucenia J. Flumer
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 27
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housework
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/5 19 27
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ Home.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
unknown
no attending physician

CONTRIBUTORY (SECONDARY) 2050
 (duration) _____ yrs. _____ mos. _____ da.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri
 10. NAME OF FATHER George Clark
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri
 12. MAIDEN NAME OF MOTHER Martha Hester
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

14. INFORMANT Martha Hester
 (Address) Carmichael
 15. FILE June 3 1927 A. A. Martin REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mason Cemetery DATE OF BURIAL 5-6 1927
 20. UNDERTAKER H. H. Smith ADDRESS Cville

~~James P. ...~~
2200 - 15 - 1900

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Linn Registration District No. 657 File No. _____
 Township Little Prairie Primary Registration District No. 5862 Registered No. 60
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME

Lunera Plummer
 (a) Residence. No. _____ St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

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

14. _____

INFORMANT (Address) _____

15. _____

File July 13, 1937 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1937

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him alive _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (duration) yrs. mos. ds.
 SECONDARY (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. P. Petty, M. D.
19 (Address) Courtsville 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 DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

WRITE FULLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

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