

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

Do not use this space.

22909

1. PLACE OF DEATH

County Auburn
Township Culture
City Forbes (No. _____) St. _____ Ward _____

Registration District No. 991
Primary Registration District No. 4557

File No. _____
Registered No. _____

2. FULL NAME

Leona M. Colburn

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

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
40 1 10

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER John Barnes

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

12. MAIDEN NAME OF MOTHER E. Pepton

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

14. INFORMANT Wm Colburn
(Address)

15. Aug 9 25 W. H. May
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 31 1925

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1925, to July 31, 1925, that I last saw him alive on July 25, 1925, and that death occurred, on the date stated above, at 10:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Organic heart disease

Ascites (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Ascites (duration) 7 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Place of Death
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
(Signed) W. H. Medley, M. D.

7-31-1925 (Address) Ladsonia 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 Vandalia Mo DATE OF BURIAL Aug 2 1925

20. UNDERTAKER W. S. Waters ADDRESS Vandalia

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.

State
Inst.

U. S. DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D. C.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Redburn Registration District No. 921 File No. _____
 Township Gardner Primary Registration District No. 4557 Registered No. _____
 City Gardner (No. _____) St. _____ Ward _____

2. FULL NAME Lina M. Collins
 (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 F 4. COLOR OR RACE W 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) 6-21-1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
40 1 10

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (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. FILED 9/19/28 St. Mary REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Oxytic heart disease
valvular heart disease
 (duration) yrs. mos. ds. _____

CONTRIBUTORY (SECONDARY) ascites
 (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) _____, M. D.
 _____, 19____ (Address)

*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 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES, UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly interpreted. Exact statement of OCCUPATION is very important.

