

Every item of information should be carefully checked. PHYSICIANS should state EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

1929

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

Do not use this space.

887

1. PLACE OF DEATH

County Mont

Registration District No. 286

Township Salem

Primary Registration District No. 8108

City Salem

(No.       )

File No.       

Registered No. 90

St.        Ward       

2. FULL NAME

Mrs. Lurania Francis Black

(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Jessie Alexander Black

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

7. AGE

YEARS

MONTHS

DAYS

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

5-8

3

7

8. OCCUPATION OF DECEASED

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

Housekeeper

(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)

Reynolds Co. Mo.

10. NAME OF FATHER

Hamilton Parker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Franklin Co. Mo.

12. MAIDEN NAME OF MOTHER

Elizabeth Adams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Reynolds Co. Mo.

14. INFORMANT

(Address)

Rochel Parker

Salem, Mo.

15. FILED

1/9 29 H. E. Rudolph, Jr.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 18 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 17 1929, to Jan. 18 1929

that I last saw her alive on Jan. 18 1929, and that death occurred, on the date stated above, at 4:30 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Strangulated Hernia

1220

118

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. 1 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) H. E. Rudolph, Jr., M. D.

, 19 (Address) Salem, 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

Miner Cemetery

Jan. 19 29

20. UNDERTAKER

ADDRESS

C. K. Spencer

Salem, Mo.

TOP SECRET

SECRET

SECRET

FEB 2

**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 De WittRegistration District No. 266

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 4164Registered No. 30City Salem

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**Laurania Francis Black

(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

W5. SINGLE, MARRIED, WIDOWED OR  
DIVORCED (write the word)W5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OF

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

Aug. 11, 1870

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1  
day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.5827

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

1/19 1929, W. E. Rued, Jr., Ill.

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 18 1929 19

17.

I HEREBY CERTIFY, That I attended deceased from

19\_\_\_\_, to 19\_\_\_\_, 19\_\_\_\_

(that I last saw him, \_\_\_\_\_, since on \_\_\_\_\_, 19\_\_\_\_, and that  
death occurred, on the date stated above, at \_\_\_\_\_m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY  
(SECONDARY)

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(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

WRITE PLAINLY, WITH CORRECT SPELLING. THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. Any 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.

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

5-887