

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

Do not use this space.

5377

**1. PLACE OF DEATH**

County..... Barry ..... Registration District No. 30 ✓  
 Township.....  
 City..... Manly (No. .... Primary Registration District No. 3003 .....  
 File No. ....  
 Registered No. 24 .....  
 St. .... Ward)

**2. FULL NAME**

Linaua An Lester  
 (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**

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 Fred Lester

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6-1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
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**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) Lawrence Co  
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Carey Baucher

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

12. MAIDEN NAME OF MOTHER Carol Hinchouse

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

14. INFORMANT W.C. Lester  
 (Address) Perse City Mo

15. FILED 2-12-29 W.M. West  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1929 until Feb 11, 1929 that I last saw her alive on Feb 11, 1929, and that death occurred, on the date stated above, at 6 p m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Fracture of hip  
from Jan. 20, 1929  
186A  
194B (duration) yrs. mos. da.  
 CONTRIBUTORY (SECONDARY) Senility, Influenza  
 (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) W.M. West, M. D.

, 19 (Address) Monett 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 Baucher Cem. DATE OF BURIAL 2-13-29

20. UNDERTAKER Wm. Wessell Perenity ADDRESS

PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important.

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**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 Daviess  
Township Monett  
City Monett (No. ...., St. .... Ward)

Registration District No. 30  
Primary Registration District No. 3003

File No. ....  
Registered No. 24

**2. FULL NAME**

Liviana Sue Lester  
(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 M  
(write the word)

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  
(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)

**PARENTS**  
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. W.M. West REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 11 1929

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 ... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Great age of his from fall while working around in house  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility, Influenza  
(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? 5

(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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

FILED 2-13-19-29

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