

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

Do not use this space.

7549

1. PLACE OF DEATH

County Shelby
Township Miller
City (No.) St. Ward)

Registration District No. 677
Primary Registration District No. 5903

File No.
Registered No. 17

2. FULL NAME

Laura A. Workman

(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 married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 11, 1845

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
81 11 26

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) State Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER Peter Hauber

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

12. MAIDEN NAME OF MOTHER D. K.

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

14. INFORMANT Jas. Workman
(Address) Vikey Mo.

15. FILED Feb. 6, 1929. Jan. 7. Ryan
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 5, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1929, to Feb. 5, 1929, that I last saw him alive on Feb. 5, 1929, and that death occurred, on the date stated above, at 9 8 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
117
107. A
..... (duration) yrs. mos. 10 ds.
CONTRIBUTORY Bronchial Pneumonia
SECONDARY (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, home

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) Geo. W. Horton, M. D.

Feb. 6, 1929 (Address) Rolla 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 Home Cemetery DATE OF BURIAL Feb. 7 1929

20. UNDERTAKER Null & Biehlides ADDRESS Rolla, Mo.

**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 Phelps Registration District No. 677 File No.
Township Miller Primary Registration District No. 5903 Registered No. 17
City (No.) St. Ward)

2. FULL NAME

Laura A. Workman
(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) Feb 11 - 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 11 24

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)
(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 3/13/29 Jos. F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 5 - 1929

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
that I last saw h..... alive 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.

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

S-7549