

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

Do not use this space.

20625

1. PLACE OF DEATH

County Barton Registration District No. H1
 Townshp. Liberal Primary Registration District No. 5062
 City Liberal (No. 1) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

(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.

Laura Jane Bainter

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ray E. Bainter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-5-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
46 8 17

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) Litchfield
 (STATE OR COUNTRY) Kansas

10. NAME OF FATHER Mathew Hamilton

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

12. MAIDEN NAME OF MOTHER Anna Bishop

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

14. INFORMANT Ray E. Bainter
 (Address) Liberal Mo.

15. FILED 7/10 19 29 F. R. Spell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1 1929 to June 17 1929 that I last saw her alive on June 17 1929, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Metastasis

2. Cholecystitis (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? yes DATE OF 1924

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Blood chemistry
 (Signed) F. R. Spell M.D.

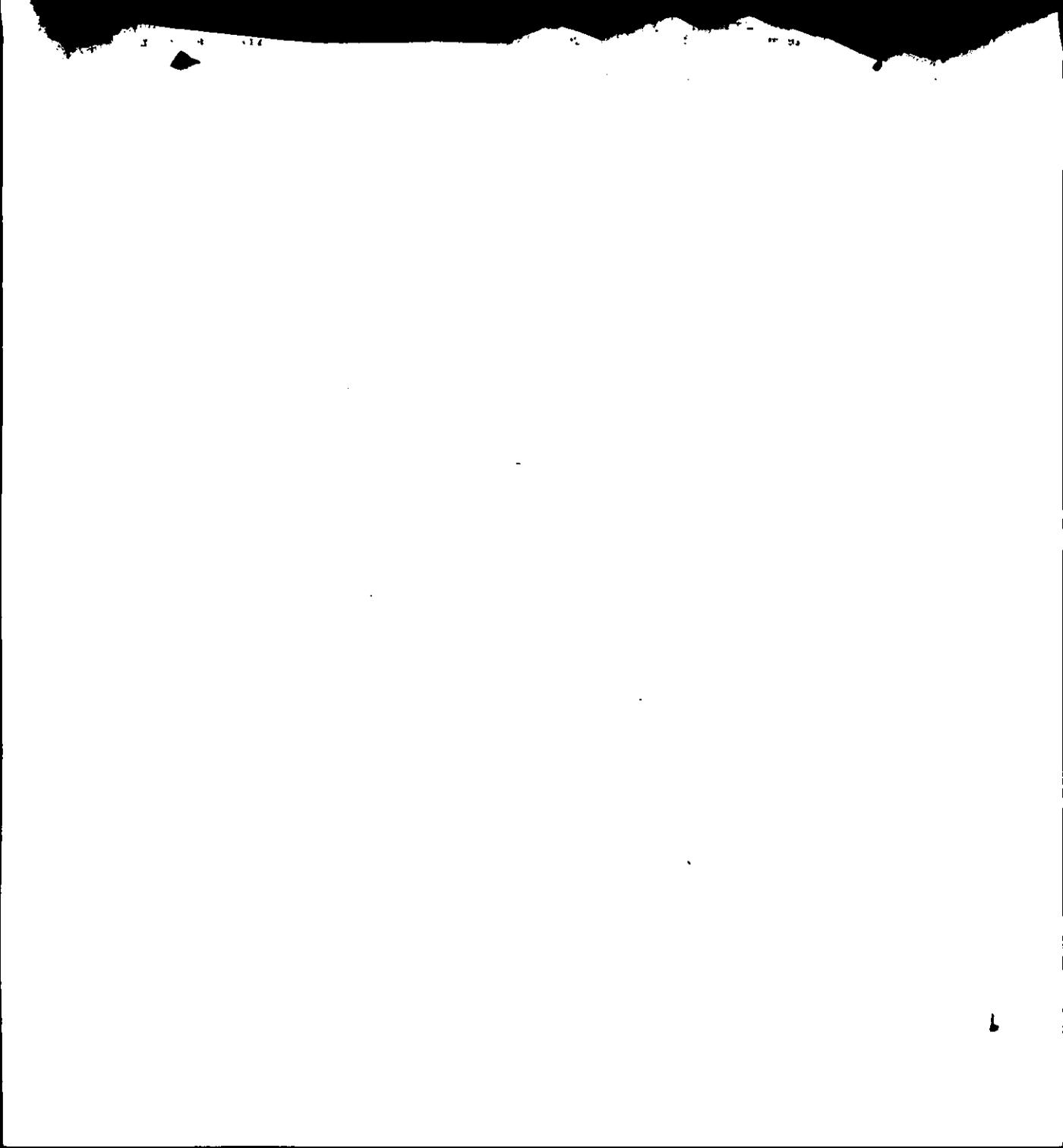
, 19 (Address) Liberal Mo.

*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 Liberal O.O.F. Cemetery DATE OF BURIAL 6-19 1929

20. UNDERTAKER L. F. Conway ADDRESS Kansas

MISSOURI STATE BOARD OF HEALTH, 801 N. 7TH ST., KANSAS CITY, 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 Barton

Registration District No. 41

File No.

Township Liberal

Primary Registration District No. 4023

Registered No.

City Liberal (No.)

St. Ward)

2. FULL NAME

Louisa Jane Painter

(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)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs.

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.

FILED

Apr. 10, 1929

J. R. Bell

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 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:

Acidosis
Non-diabetic
Cholecystitis

CONTRIBUTORY (SECONDARY)

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).....

, 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

20. UNDERTAKER

ADDRESS

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it can be properly classified. Exact statement of OCCUPATION should be stated. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. REGISTRY—DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

124B

S-20622