

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

Do not use this space.

24255

1. PLACE OF DEATH

County Franklin Registration District No. 289
Township Cotton Hill Primary Registration District No. 5407
City (No.) St. Ward

File No.
Registered No.

2. FULL NAME

Laura Belle Meins
(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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED
WIFE OF A. W. Meins
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 22-1890

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
39 4 25

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) House keeping
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Advanced
Stoddard Co Mo

10. NAME OF FATHER James Nation

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mabel Cosvo.

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

14. INFORMANT A. W. Meins
(Address) Malden Mo

15. FILED 7/18, 1929 S. E. Mitchel
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to July 17th, 1929.
that I last saw her alive on July 10th, 1929, and that death occurred, on the date stated above, at 10:45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis

23 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) JK (duration) 4 yrs. 4 mos. ✓ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. ✓

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF ✓

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS Clinical symptoms
(Signed) S. E. Mitchell, M. D.
7/19, 1929 (Address) Malden 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
Stanfield Cemetery 7/19 1929

20. UNDERTAKER ADDRESS
Walter Hubbard Malden Mo

WITH UNFADING INK---THIS IS A PERMANENT RECORD AUG

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.

1929 35

293

31

9

