

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

Do not use this space.

27375

1. PLACE OF DEATH

County Douglas
Township Leitch
City _____ (No. _____ St. _____ Ward _____)

Registration District No. 1075
Primary Registration District No. 5

File No. _____
Registered No. 2

2. FULL NAME

Bonnie Lorene Gulbreath

(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 girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

6A. 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.
1 11 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Seymour MO R5
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER J. J. Gulbreath
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Geo
(STATE OR COUNTRY) Georgia
12. MAIDEN NAME OF MOTHER Emma Cook
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) MO
(STATE OR COUNTRY)

14. INFORMANT H M Painter
(Address) Seymour MO

15. FILED Aug 24 1929 J B Hale
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 24 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 5 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

130
Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 160
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

9 WAS THERE AN AUTOPSY? _____

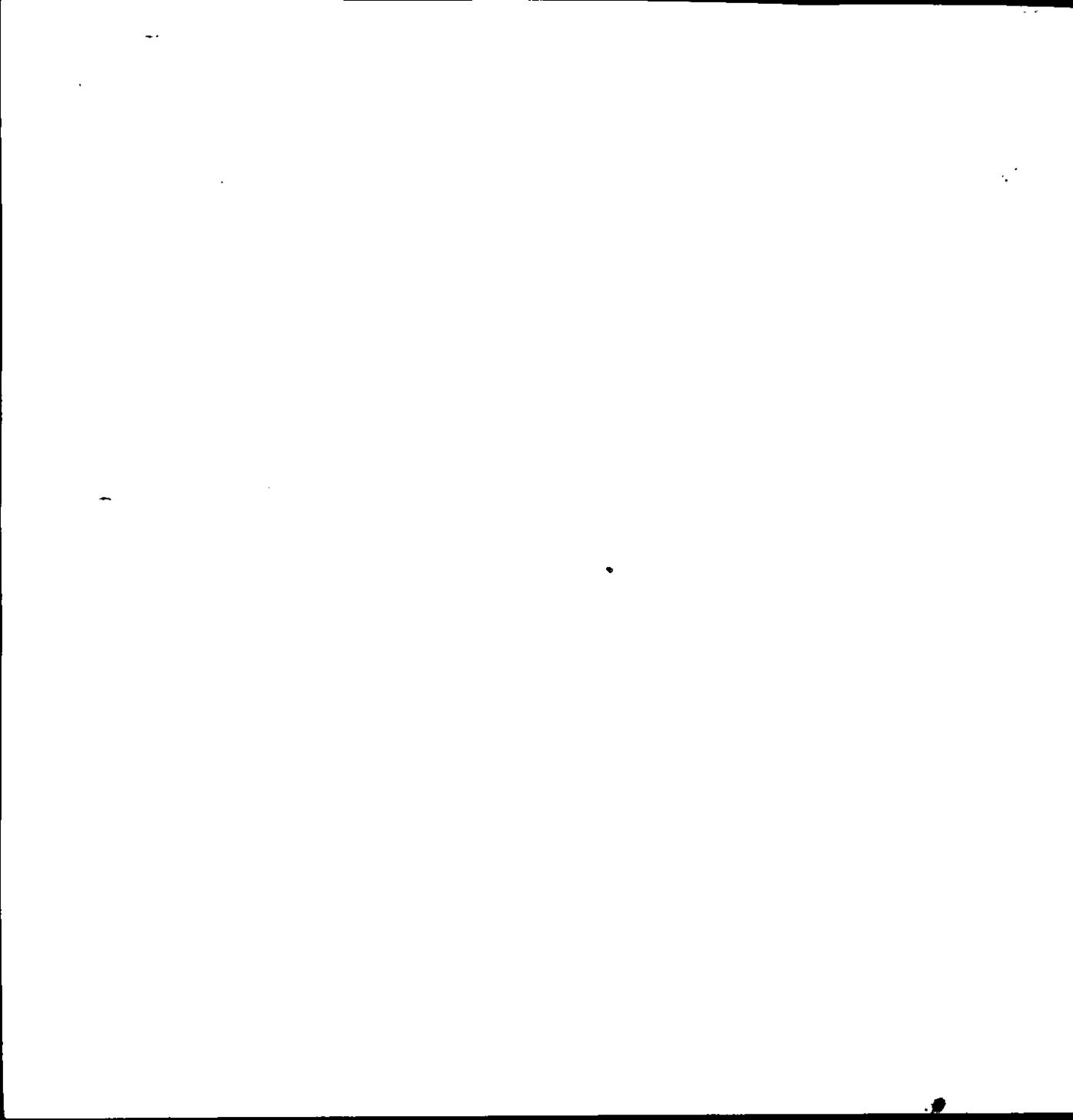
WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. J. Gulbreath, M. D.
. 19 _____ (Address) Ave 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 Hogwood Cem. DATE OF BURIAL Aug 24 1929

20. UNDERTAKER Neighbors ADDRESS _____



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