

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

Do not use this space.

2070

1. PLACE OF DEATH

new ton.
Township new tonia
City (No.)

Registration District No. 614
Primary Registration District No. 1811

File No.
Registered No.
St. Ward

2. FULL NAME

Leura Thomas Pearson

(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) widowed

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 2 4

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) Boone Co MO.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Thomas Ridgway
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Boone Co MO.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Jane Gordon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Calamba MO.
(STATE OR COUNTRY)

14. INFORMANT Mrs. Chapman
(Address) Diamond drs

15. FILED Feb 1930 M. J. Rolens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Jan 9, 1930, that I last saw her alive on Jan 8, 1930, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Flu
93.4
110
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Mitral Insufficiency
Sent Kneel (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. J. Rolens, M. D.

in 90, 1930 (Address) Granby 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
reinterred MO Jan 14 1930

20. UNDERTAKER. Bingham. ADDRESS Newsham

Every item of information supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

FEB 19 1930

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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 Newton Registration District No. 614 File No. 20
 Township Newton Primary Registration District No. 3811 Registered No. 2
 City (No.) St. Ward

2. FULL NAME Lura Thomas Benson

(a) Residence. No. St. Ward. (If nonresident give city or town and State)
 (Usual place of abode)

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) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-13-1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 2 4

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)

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 10 1938 J. W. F. Benson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1930

17. I HEREBY CERTIFY, That I attended deceased from 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. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? (duration) yrs. mos. da.

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

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 OCCURRENCE should be supplied. EXACT STATEMENT OF OCCURRENCE should be supplied. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS SHOWN BY LAW.

SUPPLEMENTARY

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