

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

Do not use this space.

2360

1. PLACE OF DEATH

County Ray Registration District No. 744 File No. _____
 Township Richmond Primary Registration District No. 3035 Registered No. 7
 City Richmond (No. _____) St. _____ Ward _____

2. FULL NAME Laura Belle Dolphin

(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 Fe	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10 1929				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	0	6	14	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work Infant				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer _____				

I MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 24 1930** 19__

17. I HEREBY CERTIFY, That I attended deceased from 1-19 1930, to 1-24 1930 that I last saw her alive on 1-23, 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia

107A (duration) _____ yrs. _____ mos. 7 ds.

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

9. BIRTHPLACE (CITY OR TOWN) Richmond Mo
 (STATE OR COUNTRY) _____

PARENTS	10. NAME OF FATHER <u>Raine Dolphin</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Richmond Mo</u>
	12. MAIDEN NAME OF MOTHER <u>Elizabeth Berry</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ray Co Mo.</u>

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Geo. J. Cook M. D.
1-27 1930 (Address) Richmond Mo

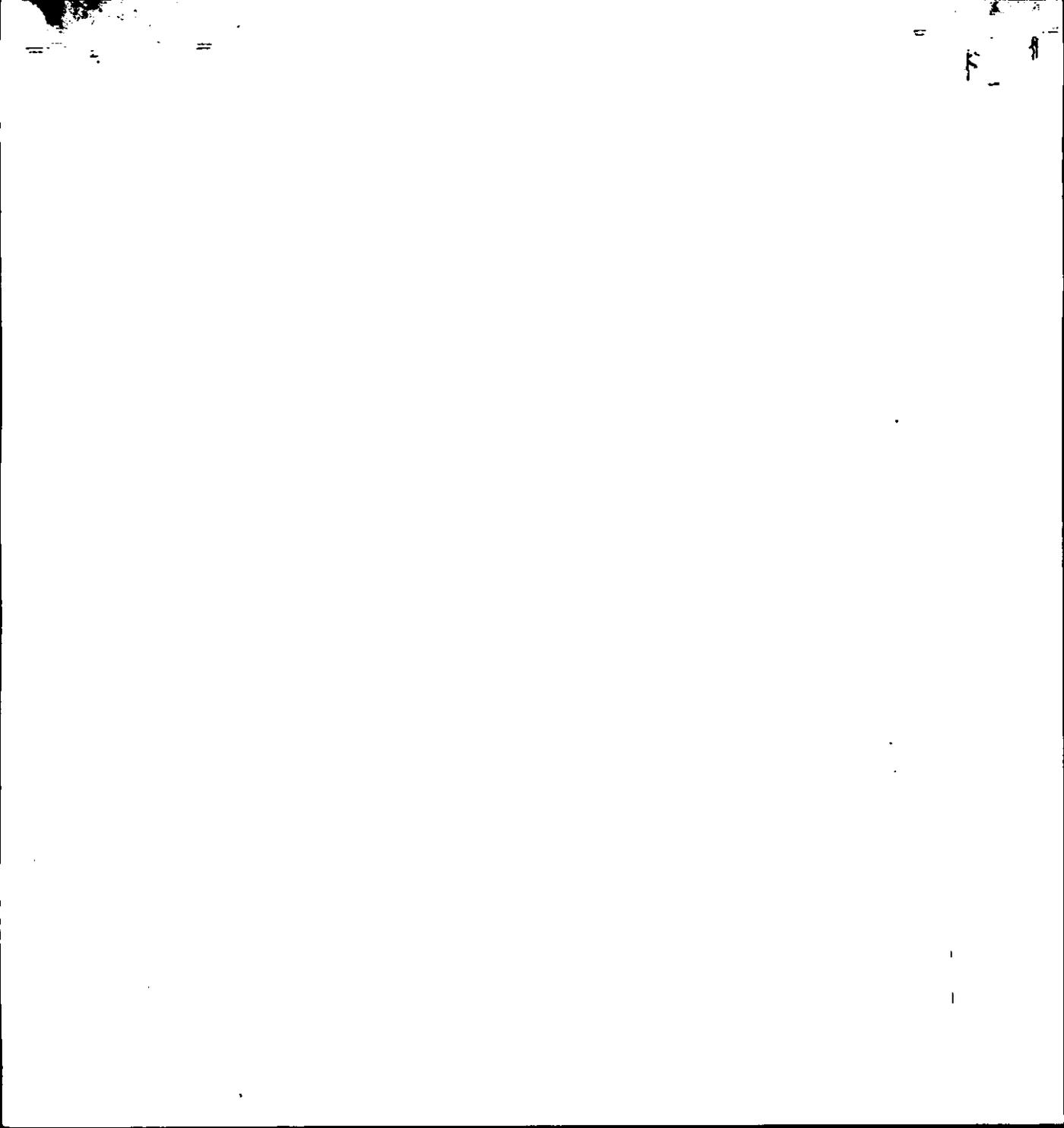
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Raine Dolphin
 (Address) Richmond Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sunny Slope Cem. DATE OF BURIAL 1-26-30 19__

20. UNDERTAKER Ch. W. Mansur ADDRESS Richmond Mo

15. Jan 31 1930 E. E. Gay REGISTRAR



**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 Ray Registration District No. 944 File No. _____
 Township _____ Primary Registration District No. 3035 Registered No. 7
 City Richmond (No. _____) St. _____ Ward _____

2. FULL NAME Laura Belle Dolph
 (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 S.
(write the word)

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. or _____ min.
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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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jun 24 19 30

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:
Pneumonia
Broncho Pneumonia
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ 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.

14. INFORMANT _____ (Address) _____

15. FILED Jun 30 19 30 E. E. Gay REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

RS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESC

SUPPLEMENTARY

S-2360