

MAR 27 1930

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

Do not use this space.

5512

1. PLACE OF DEATH

County Laclede
Township Franklin
City..... (No..... St..... Ward)

Registration District No. 95-2
Primary Registration District No. 3617

File No.....
Registered No.....
St..... Ward)

2. FULL NAME Minnie R. Pease

(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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 24-1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
29 11 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work bird at home
(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) Laclede Co Mo

10. NAME OF FATHER John W Pease

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Newtown Co Mo

12. MAIDEN NAME OF MOTHER Sarah Harris

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

14. INFORMANT Catherine Pease (Address) Orla Mo

15. FILED Feb. 30 1930 Idabelle Leckie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/9 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to Feb 9, 1930 that I last saw her alive on Feb 7, 1930 and that death occurred, on the date stated above, at 5:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis Pulmonary
23A

CONTRIBUTORY (SECONDARY) about 2 1/2 (duration) 2 yrs. mos. ds.

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

9 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? Tubercular test no

WHAT TEST CONFIRMED DIAGNOSIS? Tubercular test

(Signed) M. H. Casey, M. D. , 19 (Address) Lebanon 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 Haugh Chapel DATE OF BURIAL 2-10 1930

20. UNDERTAKER Holman Stewart ADDRESS Lebanon Mo

