

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

Do not use this space.

7350

1. PLACE OF DEATH

County Schuyler Registration District No. 806
 Township Pratt Primary Registration District No. 4485
 City Queen City (No. _____) St. _____ Ward _____

2. FULL NAME

Laura May Green
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. _____ da. How long in U. S., if of foreign birth? yrs. _____ mos. _____ da.

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 no
 HUSBAND OF (OR) WIFE OF Frank Green

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 3 - 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 . 19

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) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Wymon Iowa
 (STATE OR COUNTRY)

10. NAME OF FATHER Carroll Beauchamp

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pa
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Ziegler

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

14. INFORMANT G. F. Green
 (Address) Queen City Mo

15. FILED Feb 25 30 1930
G. F. Green REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/22 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to Feb 22, 1930
 that I last saw her alive on Feb 22, 1930 and that death occurred, on the date stated above, at 3:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of bowels
11/3 (duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Anemia
 (duration) _____ yrs. 19 mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 9/29

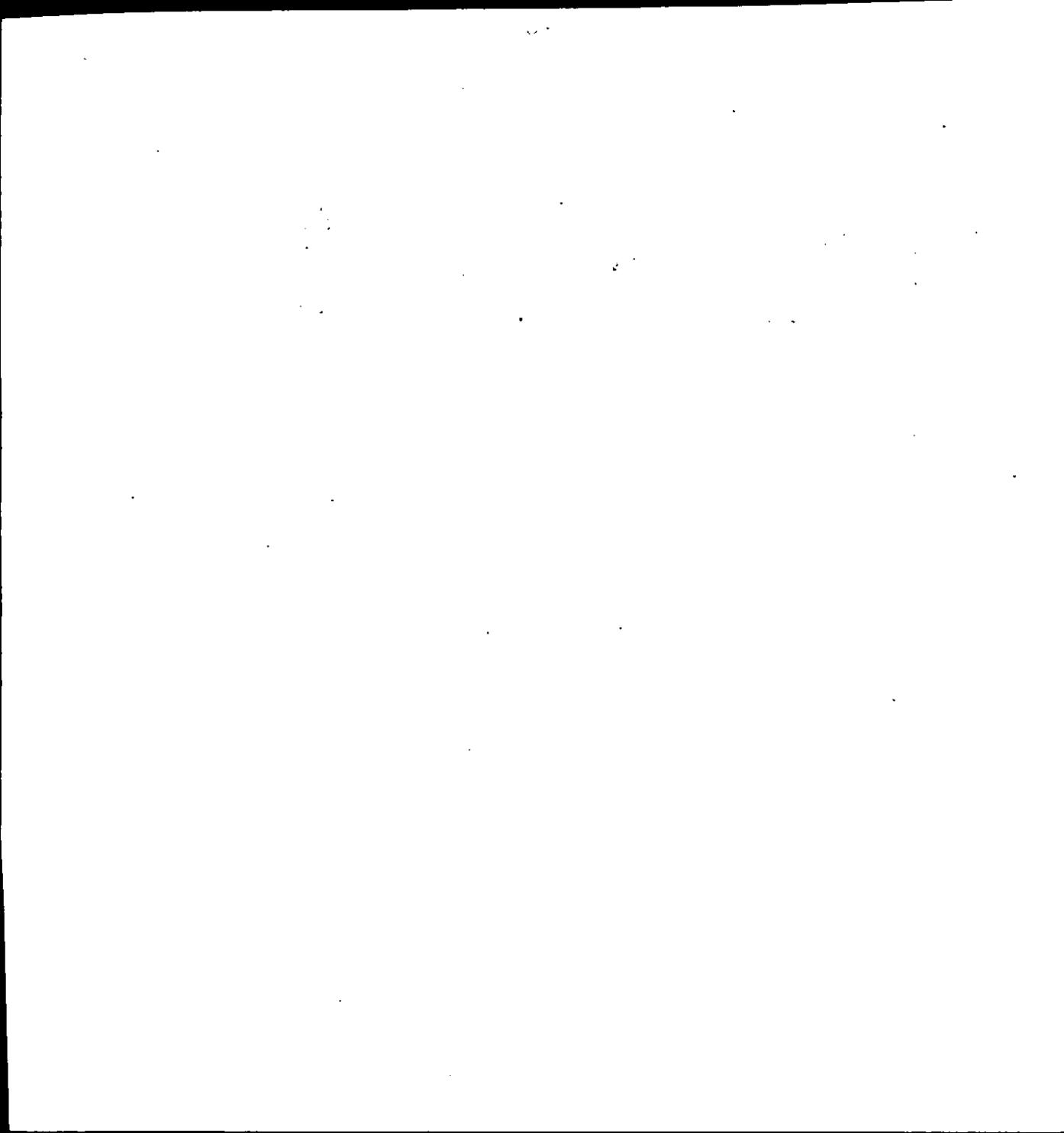
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Cancerous tumor
57102
 (Signed) _____ M. D.
 , 19 _____ (Address) Queen City 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 Wimberd Iowa DATE OF BURIAL 2/25 1930

20. UNDERTAKER Wm West ADDRESS Queen City Mo



**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 Schuyler

Registration District No. 806

File No. _____

Township Queen City

Primary Registration District No. 4485-

Registered No. _____

City Queen City (No. _____) St. _____ Ward _____

2. FULL NAME Laura May Green

(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 M (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.

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. FILE NO. 2-30-30 REGISTRAR J. A. Jones

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/22 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of bowel
extending to duodenum
and upper part of stomach
and upper part of small intestine

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

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF BIRTH _____

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 _____

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-7350