

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

Do not use this space.

40281

1. PLACE OF DEATH

County Ozark

Registration District No. 920

Township Gasper

Primary Registration District No. 5859

City (No.)

File No. _____

Registered No. 4

St. _____ Ward _____

2. FULL NAME

(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 2 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)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Austin Harper

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

March 18 1906

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

24

8

9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Invalide

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Isabella

(STATE OR COUNTRY)

Ozark Co Missouri

10. NAME OF FATHER

Joseph Washington Lantz

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Yellville

(STATE OR COUNTRY)

Marion Ark

12. MAIDEN NAME OF MOTHER

Lily May Estes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Yellville

(STATE OR COUNTRY)

Marion Ark

14. INFORMANT

Reola Lantz

(Address)

Isabella m

15. REGISTRAR

Jan 5 1931 Mary T. Johnson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec 26 1930

17.

I HEREBY CERTIFY, That I attended deceased from _____ 19____

that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lung

23H

(duration) 1 yrs. 3 mos. 18 ds.

CONTRIBUTORY (SECONDARY)

(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? no medical aid

(Signed) Reola Lantz M. D.

Jan 4 1931 (Address) Isabella m

*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

Isabella Cemetery Dec 27 1930

20. UNDERTAKER

ADDRESS

J. W. Lantz Isabella m

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 OCCUPATION is very important.

21 1931

100

100