

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

Do not use this space.

27869

1. PLACE OF DEATH

County Crawford Registration District No. 231
Township Union Primary Registration District No. 5315
City Chazyville Mo (No. _____) St. _____ Ward _____

2. FULL NAME Laura Mae Godbey

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

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 1

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

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

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford

FATHER
13. NAME Herman Godbey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford

MOTHER
15. MAIDEN NAME Mable Godbey
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford

17. INFORMANT (ADDRESS) Herman Godbey

18. BURIAL, CREMATION, OR REMOVAL PLACE New Home DATE 8-31 1931

19. UNDERTAKER (ADDRESS) Sharon M. Gosson
St. Louis

20. FILED 8-31 1931 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 14 1931, to Aug 30 1931
I last saw her alive on Aug 18 1931. Death is said to have occurred on the date stated above, at 11:30 a. m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
8-18-31

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? Physical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury Aug 8 1931
Where did injury occur? Home, Crawville Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury Fall from bed
Nature of injury Striking head on floor

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) R. G. Parker M. D.
(Address) St. Louis Mo

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

SEP 22 1931

**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 Crawford
Township Union
City (No. St. Ward)

Registration District No. 231
Primary Registration District No. 2315

File No.
Registered No.

2. FULL NAME

Lorella Mae Godhey
(a) Residence No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-20-30

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 4 X 0 X

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(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 2-31-31 C. H. Gibbs

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 19 31

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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?

(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

New Home Cemetery 2-31-1931

20. UNDERTAKER ADDRESS

H. M. Jones Steebelle

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' statements of OCCUPATION is very important. CAUSE REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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