V. S. No. 2. A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

26663

1 PLACE OF DEATH

...ty Lincoln

...ship Bedford

...ge Troy (NO. ..... St.; ..... Ward)

Registration District No. 491 File No. .....

Primary Registration District No. 5654 Registered No. 70

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

...FULL NAME Laura Bell Holtz

...PERSONAL AND STATISTICAL PARTICULARS

...ale | 4 COLOR OR RACE White | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

...E OF BIRTH Aug (Month) 25 (Day) 1903 (Year)

28 yrs. 11 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

...UPATION ...rade, profession, or ...cular kind of work House wife

...eneral nature of industry ...ess or establishment in ... employed (or employer) 235

...HPLACE ...r town, ... foreign country) Iron Co Mo 1

10 NAME OF FATHER Monroe Mayfield

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Goodland Mo

12 MAIDEN NAME OF MOTHER Cora Brummert

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Goodland Mo

...ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

...ormant) Wm Holtz

(Address) Troy Mo

...d Aug 6th 1932 W. P. Smith Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 5 (Day) 1932 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 6, 1932, to Aug 5, 1932, that I last saw her alive on Aug 1st, 1932, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

11CA

99A

100 (1)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Thrombo Phlebitis of left Femoral vein

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Smith M. D.

..... 191 ..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ✓ yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? ✓

Former or usual residence ✓

19 PLACE OF BURIAL OR REMOVAL Iron Co Mo | DATE OF BURIAL Aug 8th 1932

20 UNDERTAKER Common Corner | ADDRESS

V. S. No. 2. 4

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occur
hospital or ins
give its NAME
of street and nu

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191.

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., 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:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Caus
(1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran
or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL .....,
20 UNDERTAKER	ADDRESS