

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

Do not use this space.

JUN 3 1935

14006

1. PLACE OF DEATH

County Randolph
Township
City Moberly (No. St. Ward

Registration District No. 795
Primary Registration District No. 9094

File No.
Registered No. 84

2. FULL NAME

Laura Belle Oliver
(s) Residence, No. 627 S. 4th St., Ward.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 20 1935

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

22. I HEREBY CERTIFY, That I attended deceased from Apr. 14 1935, to Apr. 19 1935

I last saw him alive on Apr. 19 1935 Death is said to have occurred on the date stated above, at 6 a. m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 19 34

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 6 1

Pneumo-pneumonia Date of onset

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

Other contributory causes of importance:

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

13. NAME Frank Oliver

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

15. MAIDEN NAME Hagle Althouse

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT Hagle Oliver (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly, Mo. DATE 4/21 1935

19. UNDERTAKER Robert Carr (ADDRESS) Moberly, Mo.

20. FILED 4/21 1935 Virginia Moberly (Address) Mo.

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no.
If so, specify..... (Signed) H. H. Ferguson, M. D.

Exact statement of OCCUPATION is very important.



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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County Randolph Registration District No. 735
 Township Primary Registration District No. 3034
 City Moberly (No., St. Ward)

File No.
 Registered No. 84

2. FULL NAME

Lanka Belle Oliver

(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 B. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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.
		<u>6</u>	<u>1</u>	

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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 7/1 1935 Virginia Walker Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 20 1935

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Brochis Pneumonia following measles
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify.....
 (Signed)....., M. D.

(Address).....

SUBMITTED

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JUN 25 1985