

FEB 19 1937

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

Do not use this space.

1. PLACE OF DEATH

County, Newton Registration District No. 615-
Township, Masson Primary Registration District No. 5817
City, _____ (No. 22) _____ St. _____ Ward) _____

File No. 2434
Registered No. 3

2. FULL NAME

Vera Reis Cooner

(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) use 18.1936
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 5

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. Infant
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) Newton Co Missouri

13. NAME A. S. Cooner

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

15. MAIDEN NAME Elva Wells

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

17. INFORMANT (ADDRESS) A. S. Cooner in

18. BURIAL, CREMATION, OR REMOVAL PLACE High Valley DATE 1-24 1937

19. UNDERTAKER (ADDRESS) Bryham's

20. FILED Jan 8th 1937 Mrs. U. S. Chapman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-23 1937

22. I HEREBY CERTIFY, That I attended deceased from Jan 22 1937, to Jan 23 1937
I last saw her alive on Jan 24 1937. Death is said to have occurred on the date stated above, at 5:30 A.M.
The principal cause of death and related causes of importance were as follows:

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

Bronchial pneumonia Jan 12
Date of onset _____
Other contributory causes of importance: _____
none

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

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. C. Bowman, M. D.
_____ (Address) Keosauqua Mo.

107a

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

Do not use this space.

1. PLACE OF DEATH

County Newton
Township Marion
City (No. _____) _____ (No. _____) _____

Registration District No. 615
Primary Registration District No. 5817

File No. 2434
Registered No. _____

2. FULL NAME

Jena Lois Conner

(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. (write the word) Single

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. 9 5

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 Jan 8th 1937 Mrs. U. S. Chapman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-23, 1937

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

I last saw him/her alive on _____, 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: _____ Date of onset _____

Supplemental
Bronchial pneumonia
There were no complications prior to, or along with the pneumonia.

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. C. Bowman, M. D.

(Address) Peashe

15125

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