

APR 30 1929

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

Do not use this space.

11938

1. PLACE OF DEATH

County Putnam  
Township York  
City Powersville (No. ....)

Registration District No. 724  
Primary Registration District No. 5953

File No. ....  
Registered No. 4 St. .... Ward)

2. FULL NAME

Laura Ellen Collins

(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) Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
61 11 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer) ..  
(c) Name of employer ..

9. BIRTHPLACE (CITY OR TOWN) Putnam Co  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Frank Godberry

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..  
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Sarah Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..  
(STATE OR COUNTRY) Putnam

14. INFORMANT Carl Briggs  
(Address) Shenadash Road

15. FILED 3/27/29 1929 J. H. Goad REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1929 to Mar 1 1929 and that I last saw her alive on Mar 1 1929 and that death occurred, on the date stated above, at .. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Apoplexy

CONTRIBUTORY (SECONDARY) None  
(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) J. H. Goad M. D.  
3-2-1929 (Address) Powersville Mo

\*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 Powersville Cem DATE OF BURIAL Mar 3 - 1928

20. UNDERTAKER Boyer and Statten ADDRESS ..

CAUSE OF DEATH IN plain terms, so that it may be properly understood. - Exact statement of OCCUPATION necessary and important.

PARENTS

Fromerstein



**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 Putnam Registration District No. 724 File No. \_\_\_\_\_  
 Township Yonca Primary Registration District No. 3733 Registered No. 4  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Laura Ellen Collins

(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) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 16 - 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>61</u>	<u>11</u>	<u>15</u>		

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

<b>PARENTS</b>	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 3-27-29 J. J. Ford REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/11/29

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 \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) yrs. mos. 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? \_\_\_\_\_  
 (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 _____
	19 _____

20. UNDERTAKER _____	ADDRESS _____
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SUPPLEMENTARY

N. B.—Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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