

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

Bohling
65834

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.

APR 25 1931

1. PLACE OF DEATH
 80 County Pittsburg Registration District No. 668
 Township Seeger Primary Registration District No. 5894
 City Seedalia (No. R.F.D. #5 2 mi. N. city) St. _____ Ward _____
2. FULL NAME Laura Jane Billingsley
 (a) Residence No. R.F.D. #5 Seedalia, Mo. 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 18 1859

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>71</u>	<u>10</u>	<u>10</u>	<u>—</u>

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home 235
 (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) Ohio

10. NAME OF FATHER Wm. Gahrlich

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo. 131

12. MAIDEN NAME OF MOTHER Abbie Ludlow

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

14. INFORMANT H. J. Billingsley
 (Address) Seedalia Mo.

15. FILED 3-10-31 1931
H. J. Cox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1931

17. I HEREBY CERTIFY That I attended deceased from Feb 27 1931 to Feb 28 1931 that I last saw her alive on Feb 27 1931, and that death occurred, on the date stated above, at 6:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108

(duration) _____ yrs. _____ mos. 6 ds.

CONTRIBUTORY (SECONDARY) None
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Boyd Bohling, M.D.
3-3-31 (Address) Seedalia 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 <u>Crown Hill</u>	DATE OF BURIAL <u>3/3 1931</u>
20. UNDERTAKER <u>Tilluspin</u>	ADDRESS <u>Seedalia</u>

