

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

PLACE OF DEATH *✓*

County *Maure*  
Township *Liberty*  
or  
Village  
or  
City *Palmyra* (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. *548* File No. *7127*  
Primary Registration District No. *4323* Registered No. *19*

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

FULL NAME *Mary C Tiefenbunn*

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

SEX *Female* COLOR OR RACE *White* SINGLE MARRIED WIDOWED OR DIVORCED *Married*  
(Write the word)

DATE OF DEATH *FEB 13*, 191*1*  
(Month) (Day) (Year)

DATE OF BIRTH *Apr 13*, 18*33*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Southview*, 191*1*, to *Feb 13*, 191*1*, that I last saw her alive on *Feb 11*, 191*1*, and that death occurred, on the date stated above, at *3:00* p. m. The CAUSE OF DEATH\* was as follows:

AGE *77* yrs. *10* mos. *0* ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

*Obstruction and Dropsy*  
*112*  
Contributory (SECONDARY) (Duration) \_\_\_ yrs. *6* mos. \_\_\_ ds.

OCCUPATION (a) Trade, profession, or particular kind of work *House work*  
(b) General nature of industry, business, or establishment in which employed (or employer) *1290*

BIRTHPLACE (City or town, State or foreign country) *Germany*

PARENTS NAME OF FATHER *Will Caster* BIRTHPLACE OF FATHER (City or town, State or foreign country) *Germany*  
MAIDEN NAME OF MOTHER *Don't know* BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Germany*

(Signed) *J. A. P. Wells* M. D. (Address) *Palmyra*  
\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Frank Tiefenbunn* (ADDRESS) *Palmyra*

Where was disease contracted if not at place of death? Former or usual residence

Filed *Feb 15*, 191*1*, *A. J. [Signature]* REGISTRAR

PLACE OF BURIAL OR REMOVAL *Palmyra* DATE OF BURIAL *Feb 15*, 191*1*  
UNDERTAKER *Quest Sons* ADDRESS *Palmyra*

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.

