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

33374

PLACE OF DEATH

County: Scott

Township: Moreland

or Village: ~~New Hamburg~~

or City: _____ (NO. _____ St.: _____ Ward)

Registration District No. 514 File No. ~~[illegible]~~

Primary Registration District No. 6063 Registered No. 33

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

FULL NAME Jane Bles

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem

COLOR OR RACE: Wh

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Feb (Month) 2 (Day), 1871 (Year)

AGE: 40 yrs. 5 mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: wife
(b) General nature of industry, business, or establishment in which employed (or employer): 9 d

BIRTHPLACE (City or town, State or foreign country): Kelso Township

PARENTS
NAME OF FATHER: Peter Gosche
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: M. Vollmer
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Schulte

(ADDRESS) New Hamburg Mo

Filed Sept. 8, 1911. S. J. Wade REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 1 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from July 24, 1911, to Aug 1, 1911, that I last saw her alive on Aug 1, 1911, and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

Puerpral Septicemia

145A

149B

(Duration) ___ yrs. ___ mos. 9 ds.

137

Contributory (SECONDARY) Child birth

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Uriel P. Haw M. D.

Sept. 8, 1911 (Address) Benton Mo

*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.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: New Hamburg Mo.

DATE OF BURIAL: Aug 2, 1911

UNDERTAKER: A. Dunbar

ADDRESS: New Hamburg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO. ....., ... St.; ..... Ward)

MISSOURI STATE BOARD
BUREAU OF VITAL STAT
CERTIFICATE OF DEAT

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DI

DATE OF DEATH

..... (Month)

I HEREBY CERTIFY, that I att

....., 191...., to.....

that I last saw h.....alive on.....

and that death occurred, on the date state

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths (1) Means of Injury; and (2) whether Accidental, Suicidal,

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTI RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL | DA

UNDERTAKER | AD

...statement of oc-

coma, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvu-*