

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.

PLACE OF DEATH

County Bollinger
 Township Liberty
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 940 File No. 8 8179
 Primary Registration District No. 5704 Registered No. 12

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

FULL NAME unnamed

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE Single
 MARRIED
 WIDOWED
 OR DIVORCED
 (If write the word)
 DATE OF BIRTH Mar 10, 1912
 (Month) (Day) (Year)
 AGE _____ yrs. _____ mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE

(City or town, State or foreign country) Near Leopold Mo

PARENTS
 NAME OF FATHER Christian Frankler
 BIRTHPLACE OF FATHER Near Leopold Mo
 (City or town, State or foreign country)
 MAIDEN NAME OF MOTHER Hannah Seiler
 BIRTHPLACE OF MOTHER Near Leopold Mo
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Christian Frankler
 (ADDRESS) Leopold Mo.

Filed Mar 11, 1912 J. M. Finney
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 10, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 10 6 PM, 1912, to Mar 10 10 PM, 1912, that I last saw her alive on Mar 10, 1912, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Abnormal development of heart
None (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Finney Jr. M. D.
Mar 11, 1912 (Address) Wentworth 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

Leopold Cemetery DATE OF BURIAL Mar 12, 1912

UNDERTAKER

A. A. Warren ADDRESS Lutesville Mo.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....

(NO.

Registration District No.

File No.

Primary Registration District No.

Registered No.

St. Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH

(Month), 191..... (Day), 191..... (Year)

AGE

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

..... yrs. mos. ds.

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)NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month), 191..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from

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

that I last saw h..... alive on, 191.....

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.

(Signed)

..... M. D.

(Address)

*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. State yrs. mos. ds.

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

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

191.....