PLACE OF DEATH

County Benton

Township ~~Williams~~ or Village or City Cole Camp (NO. , St.; Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 12162

Registration District No. 59 File No. ~~12062~~

Primary Registration District No. 4034 Registered No. 19

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

FULL NAME Maria Elizabeth Müller

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: June (Month) 18 (Day), 1832 (Year)

AGE: 80 yrs. 10 mos. X ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): X-9-0

BIRTHPLACE (City or town, State or foreign country): Himbergen-Germany

PARENTS
NAME OF FATHER: Johann Adam Westenberg
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Anna Margaretha Balsmeier
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P G Müller

(ADDRESS) Cole Camp

Filed Apr 24, 1913. J. P. Van Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr (Month) 24 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 20, 1913, to Apr 24, 1913, that I last saw her alive on Apr 23, 1913, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia.

(Duration) ___ yrs. ___ mos. 3 ds.

Contributory (Secondary) Lagrippe (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. P. Van Allen M. D.

Apr 24, 1913, (Address) Cole Camp 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: Trinity Lutheran Cem. DATE OF BURIAL: Apr. 27, 1913

UNDERTAKER: E. L. Eichhoff ADDRESS: Cole Camp Mo

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

PLACE OF DEATH

County _____

Township _____ *or*

Village _____ *or*

City _____ (NO. _____ _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurr
hospital or inst
give its NAME
of street and num

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 1_____
(Month) (Day) (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 DEATH

DATE OF DEATH _____, _____
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, that I last saw h____ alive on _____, and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) ____ yrs. ____ mos.

Contributory _____
(Secondary)

_____ (Duration) ____ yrs. ____ mos.

(Signed) _____

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transiei Recent Residents)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS