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.

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

PLACE OF DEATH

County: Daviess

Township: _____ Registration District No. 249 File No. 18940

or Village: ~~Salem~~ Coffeyburg Primary Registration District No. 4149 Registered No. 17

or City: _____ (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Euphema Gaeckler

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: white

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

DATE OF BIRTH: July (Month) 14th (Day), 1843 (Year)

AGE: 70 yrs. 11 mos. 13 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): _____

BIRTHPLACE (City or town, State or foreign country): Ind

PARENTS
NAME OF FATHER: James Collins
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
MAIDEN NAME OF MOTHER: Marigaret Dulitt
BIRTHPLACE OF MOTHER (City or town, State or foreign country): N Y

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bessie Gittins

(ADDRESS) Coffey Mo

Filed 6/29 1914 J A Beerle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 27th (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 16th, 1914, to June 27, 1914, that I last saw her alive on June 27, 1914, and that death occurred, on the date stated above, at 10 15 p m.

The CAUSE OF DEATH* was as follows:

Hemiplegia
Cerebral
97 (Duration) ____ yrs. 1 mos. 12 ds.

Contributory (Secondary) arteria sclerosis (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) N H Foster M. D.

June 29 1914 (Address) Coffey Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Nature 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: Fairview Cemetery

DATE OF BURIAL: June 29 1914

UNDERTAKER: W G Bunnin

ADDRESS: Coffey Mo

PLACE OF DEATH

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

County.....

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

or

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

or

City .....(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)

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

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

....., 191..... (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. 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	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS