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 Warren

Township Charrette

or

Village

or

City (NO. St.: Ward)

Registration District No. 884 File No. 31263

Primary Registration District No. 6174 Registered No. 23

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

FULL NAME Helen Bertha Ahmann

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Sept 14 (Month) (Day), 1914 (Year)

AGE: yrs. mos. ds.

If LESS than 1 day, 12 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): Warren Co Mo

PARENTS

NAME OF FATHER: F. W. Ahmann

BIRTHPLACE OF FATHER (City or town, State or foreign country): Warren Co. Mo

MAIDEN NAME OF MOTHER: Hilda Leckmann

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Warren Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Dickmann

(ADDRESS) Marthasville Mo

Filed Sept 16, 1914. C. L. Lanender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 14 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 14, 1914, to Sept 14, 1914, that I last saw her alive on Sep 14, 1914, and that death occurred, on the date stated above, at 4-30 p m.

The CAUSE OF DEATH* was as follows:

Oedemes of lungs

1610

(Duration) 9 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) C. L. Lanender M. D.

Sep 17, 1914 (Address) Marthasville

*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: Marthasville Mo

DATE OF BURIAL: 9-17, 1914

UNDERTAKER: Fred W Lichtenberg

ADDRESS: Marthasville Mo

Revised United States Standard Certificate

MISSOURI STATE BOARD OF HEALT

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 occurred hospital or instit give its NAME fr of street and numb

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 DEATH

DATE OF DEATH

.....(Month) .....(Day), 19 (

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 19

that I last saw h.....alive on....., 19

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, TRANSIEN 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