WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

15299

PLACE OF DEATH

County Bollinger

Township Liberty

or

Village

or

City

Registration District No. 940 / 5704

File No.

Primary Registration District No.

Registered No. 3

(NO. St.; Ward)

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

FULL NAME Viola Armheim

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	—

DATE OF BIRTH: Apr (Month) 25 (Day) 1914 (Year)

AGE: yrs. 11 mos. 25 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) Bollinger Co.

PARENTS

NAME OF FATHER John Armheim

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

MAIDEN NAME OF MOTHER Mary Meier

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Armheim

(ADDRESS) Advance Mo

Filed May 4 1915 C A Sanders REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr (Month) 5 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 24, 1915, to Apr 25, 1915, that I last saw her alive on Apr 4, 1915, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

197 A 91

(Duration) yrs. mos. 12 ds.

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

(Signed) J. M. Finney M. D.

Apr 5 1915 (Address) Whitewater 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: Iron Cemetery — DATE OF BURIAL: Apr 6 1915

UNDERTAKER: E. L. Potter. — ADDRESS: Advance Mo.

PLACE 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]

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

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

N. B.—Every item of information should be carefully supplied. AG CAUSE OF DEATH in plain terms, so that it may be properly cla

WRITE PLAINLY, WITH UNFADING INK.