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

PLACE OF DEATH

County: Pettis

Township or Village or City: Sedalia (NO. ____ St.: ____ Ward)

Registration District No. 668 — File No. 25507

Primary Registration District No. 3032 — Registered No. 214

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

FULL NAME: Verna Theodora Fleischbein

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Aug. 13, 1884 (Month) (Day) (Year)

AGE: 31 yrs. 0 mos. 7 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): ✓

BIRTHPLACE (City or town, State or foreign country): Atchison Kans.

PARENTS
NAME OF FATHER: Theodore E. Fleischbein
BIRTHPLACE OF FATHER (City or town, State or foreign country): St. Louis, Mo.
MAIDEN NAME OF MOTHER: Minnie Grimmer
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Quincy, Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Minnie Grimmer

(ADDRESS): Atchison Kans.

Filed Aug. 20 1915. F. B. Long, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug 20, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 17, 1915, to Aug 20, 1915, that I last saw her alive on Aug 20, 1915, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

55A Bowel Obstruction
122B

131

(Duration) ____ yrs. ____ mos. 10 ds.

Contributory (SECONDARY): Abortion, Induced — (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) K. R. Barnum M. D.

8/20 1915 (Address) Sedalia

*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: Atchison Ks. — DATE OF BURIAL: ____ 191__

UNDERTAKER: F. J. Comelson — ADDRESS: Sedalia Mo.

MISSOURI STATE BOARD OF HEALTH
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 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

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

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