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

27018

PLACE OF DEATH

County Cape Girardeau

Township ~~Cape Girardeau~~ Registration District No. 125 File No.

or Village Primary Registration District No. 3009 Registered No. 1244

or City Cape Girardeau (NO. Frederick St. St.: 2 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Pauline M. Fisher

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: Aug (Month) 24 (Day), 893 (Year)

AGE: 22 yrs. — mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Jackson Mo

PARENTS

NAME OF FATHER: Robert Litterer

BIRTHPLACE OF FATHER (City or town, State or foreign country): Jackson Mo

MAIDEN NAME OF MOTHER: Mary Bienlein

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Perryville Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed. Litterer

(ADDRESS) St Louis Mo.

Filed Sept 18, 1915 R. W. Frissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. (Month) 18 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1915, to Sept. 18, 1915, that I last saw her alive on on Sept 17, 1915, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A

(Duration) 1 yrs. ___ mos. ___ ds.

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

(Signed) J W Berry M. D.

Sept 18, 1915 (Address) 709 Broadway Cape Girardeau 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: Fairmount Cem

DATE OF BURIAL: Sept 18, 1915

UNDERTAKER: Walther F & M Co.

ADDRESS: Cape Girardeau Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death).

Association)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County .....

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

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

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

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

(If death occurred hospital or instit give its NAME in 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) .....

SEP 8 7 1953

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..... (Year)

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 Causes (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT 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