

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.

PLACE OF DEATH

County

Township

or

Village

or

City

(NO. _____)

St.: _____ Ward: _____

FULL NAME

Registration District No. 441

File No. _____

Primary Registration District No. 3243Registered No. 19

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
OR DIVORCED
(Write the word)

Female

White

Married

DATE OF BIRTH

Mar 19

(Month)

(Day)

1849 (Year)

AGE

66 yrs. 5 mos. 18 ds.

If LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

House Wife

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

BIRTHPLACE

(City or town, State or foreign country)

Germany

PARENTS

NAME OF FATHER

Nicolas Thelen

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Germany

MAIDEN NAME OF MOTHER

Margaret Thelen

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Betzer

(ADDRESS)

Edina, Minn.

Filed

Oct 10, 1915 H. J. Jurgens

REGISTRAR

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 30804B

30999

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

September 7th, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 4th, 1915, to Sept. 6th, 1915, that I last saw her alive on Sept. 5th, 1915, and that death occurred, on the date stated above, at 7³⁰ p.m. The CAUSE OF DEATH was as follows:

Incarcerated Female
Harris

Contributory

(SECONDARY)

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

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

(Signed) J. H. Jurgens M. D.

Sept. 7, 1915 (Address) Edina, Minn.

*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

St. Josephs Care Sept 8, 1915

UNDERTAKERS

ADDRESS

Kriegshaus Bros Edina, Minn.

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 _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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		
(Month) _____ (Day) _____ (Year) _____		IF LESS than 1 day hrs. or min. ?

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) _____

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:

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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 _____