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 Elkhorn

or

Village

or

City (NO. St.; Ward)

Registration District No. 881 File No. 5074

Primary Registration District No. 6171 Registered No. 44

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

FULL NAME Katharine Florentina Buschmann

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: September (Month) 5 (Day), 1832 (Year)

AGE: 83 yrs. 3 mos. 25 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(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: Not known
BIRTHPLACE OF FATHER (City or town, State or foreign country): Not known
MAIDEN NAME OF MOTHER: Not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Buschmann

(ADDRESS) Warrenton, Mo

Filed Jan 1st, 1915, E. J. Lorenthal Jr. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: December (Month) 31 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 30th, 1915, to Dec 31st, 1915, that I last saw her alive on Dec 31, 1915, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
11 A
109 A

(Duration) 91 yrs. ___ mos. 3 ds.

Contributory (SECONDARY) [illegible]

(Duration) ___ yrs. ___ mos. 6 ds.

(Signed) John H Dyer M. D.

Dec 31, 1915 (Address) Warrenton 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: Stone Church Cem

DATE OF BURIAL: Jan 2nd 1915

UNDERTAKER: F W Niehring

ADDRESS: Warrenton Mo

PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

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

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 .....

N. B.—Every item of information should be carefully supplied. AGE should be entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in such terms, so that it may be properly classified. Full Name, Place of Death, and Date of Death are very important. Correct statement of OCCUPATION is very important.

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