V. S. No. 2.

MARGIN RESERVED FOR BINDING

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

nty Cape Girardeau

nship do

ge

Registration District No. 125 File No. 9460

Primary Registration District No. 3009 Registered No. 1554

Cape Girardeau No. 911 Broadway St.: 2 Ward)

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

FULL NAME ~~Elizabeth~~ Johanna Pape

PERSONAL AND STATISTICAL PARTICULARS

X	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
nale	white	Widowed

TE OF BIRTH April (Month) 22 (Day), 1835 (Year)

E 81 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

CUPATION Trade, profession, or ticular kind of work Housewife

General nature of industry, iness, or establishment in ch employed (or employer)

THPLACE ty or town, te or foreign country) Hanover Germany

NAME OF FATHER Frederick Ristig

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

MAIDEN NAME OF MOTHER Dont know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont know

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

nformant) Herman Pape

(ADDRESS) Cape Girardeau Mo

led Mch 15", 1917. R. W. Frissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 13th (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 12th, 1917, to March 13th, 1917 that I last saw her alive on Mar 13th, 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pernicious Intermittent fever 38

0 (Duration) ....yrs. ....mos. ....ds.

Contributory (SECONDARY)

8 (Duration) ....yrs. ....mos. ....ds.

(Signed) G. B. Schultz M. D.

Mar 15th, 1917 (Address) 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

DATE OF BURIAL Mch 15" 1917

UNDERTAKER Walther's Furn & Mud Co.

ADDRESS Cape Gir. Mo

V. S. No. 2.

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MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... or Village.....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

City ..... (NO. ..... St.: ..... Ward)

(If death occurr hospital or inst give its NAME of street and num

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

..... , 1
(Month) (Day) (

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, 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 ....., 191
UNDERTAKER	ADDRESS