PLACE OF DEATH

County Cape Girardeau

Township do

or

Village

or

City Cape Girardeau (NO. 217 N. Lorimier St.; Ward)

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

Registration District No. 125 File No. 24648

Primary Registration District No. 3009 Registered No. 1632

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

FULL NAME Ferdina Boss

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: January (Month) 21 (Day), 1839 (Year)

AGE: 78 yrs. 5 mos. 18 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: Dont know
BIRTHPLACE OF FATHER (City or town, State or foreign country): " "
MAIDEN NAME OF MOTHER: Dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Boss

(ADDRESS) Cape Girardeau Mo

Filed 7/10, 1917 R. L. O'Bryan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 9th (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from January, 1917, to July 9th, 1917, that I last saw her alive on July 9th, 1917, and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of mesenter

Yes G

(Duration) yrs. 7 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. L. Cunningham M. D.

July 9 1917 (Address) Cape Girardeau

*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: Lourmier Cemetery

DATE OF BURIAL: July 11, 1917

UNDERTAKER: Walther & Hill Co

ADDRESS: Cape Girardeau Mo

CAUTION: Any person who shall knowingly or willfully make any false statement in any of the above or foregoing statements, or who shall knowingly or willfully destroy, change, or deface any property changed or delivered under this act, shall be guilty of a misdemeanor and punished as provided by law.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough;*

PLACE OF DEATH

County.....

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

MISSOURI STATE BOARD O
BUREAU OF VITAL STATIS
CERTIFICATE OF DEATH

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

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

[If hosp give of st

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) .....

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)

I HEREBY CERTIFY, that I attended

....., 191...., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated abov

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. .....

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. .....

(Signed) .....

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Vi (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homic

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF
UNDERTAKER	ADDRESS