MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 44610

1 PLACE OF DEATH

County: Buchanan

Township or Village or City: St. Joseph (NO. Ensworth Hospital St.; Ward)

Registration District No. 85 — File No. 13

Primary Registration District No. 1001 — Registered No. 1808

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

2 FULL NAME: Jennie E. Goldizen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: November 2, 1886 (Month) (Day) (Year)

7 AGE: 32 yrs. 1 mos. 14 ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Household
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Iowa

PARENTS

10 NAME OF FATHER: Chauncey Chesley

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio

12 MAIDEN NAME OF MOTHER: Della Reed

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Iowa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Brausfield,
(Address) 2921 Angelique St.

15 Filed Dec 18, 1918 H. D. Lamaster Esq Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December, 16, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 8, 1918, to Dec 16, 1918, that I last saw her alive on Dec 16, 1918, and that death occurred, on the date stated above, at 6:00 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
11 Ft
107 Ft

10

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza
(Duration) ... yrs. ... mos. 4 ds.

(Signed) J. M. Allaman M. D.
12/17, 1918 (Address) King Hill Ben

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. 2 ds. In the State 5 yrs. ... mos. ... ds.

Where was disease contracted if not at place of death? 37th. & Charles St.

Former or usual residence: 37th. & Charles St.

19 PLACE OF BURIAL OR REMOVAL: Mt. Mora Cemetery

DATE OF BURIAL: Dec, 18, 191

20 UNDERTAKER: H. O. Sidenfaden

ADDRESS: 215 No. 10th. St.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE

.....yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS