LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

5318

MAR 30 '31

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

V. S. No. 2.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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 Lincoln Registration District No. 1137 File No. 1
Township Prairie Primary Registration District No. 5651 Registered No. 15
City (No. St. Ward)

FULL NAME Friederike Caroline Louise Begeman

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
th of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
EX: Female — 4. COLOR OR RACE: White — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single	16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 1st 1927
F MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1927, to Feb 1st 1927, that I last saw h... alive on Feb 1st 1927, and that death occurred, on the date stated above, at 5-30 P.m.
ATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 15 - 1852	THE CAUSE OF DEATH* WAS AS FOLLOWS:
GE: YEARS 74 — MONTHS 11 — DAYS 16 — If LESS than 1 day, ...hrs. or ......min.	Pulmonary Stasis (duration) ....yrs. ....mos. 11 ds.
CUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping (c) Name of employer	CONTRIBUTORY (SECONDARY) Bronchitis (duration) ....yrs. ....mos. 15 ds.
RTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warren County, MO.	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
NAME OF FATHER Henry Begeman	DID AN OPERATION PRECEDE DEATH? DATE OF
BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany	WAS THERE AN AUTOPSY? WHAT TEST CONFIRMED DIAGNOSIS?
MAIDEN NAME OF MOTHER Caroline Renner	(Signed) Dr. N. L. Drunert, M. D. 2/2, 1927 (Address) Truxton Mo
BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)
NFORMANT Mrs Minnie Lietz (Address) Truxton Mo	19. PLACE OF BURIAL, CREMATION, OR REMOVAL: German M. E. Cemetery — DATE OF BURIAL: Feb 3 1927
ILED 2/2 1927 Dr. N. L. Drunert REGISTRAR	20. UNDERTAKER: D J Rivir — ADDRESS: Bellflower, Mo.

99B

LOCAL REGIS[redacted]PORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

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

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

City..... (No....., ... St. ..... W

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

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.

J. S. No. 2.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17. I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....,
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICI HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BU

20. UNDERTAKER | ADDRESS