

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

Do not use this space.

9344

1. PLACE OF DEATH

County St Charles Registration District No. 757
 Township St Charles Primary Registration District No. 9096
 City St Charles (No. 423) Clay St. 1 (Word)

File No. _____
 Registered No. 53

2. FULL NAME

Carrie Bode
 (a) Residence No. 423 Clay St. 1 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. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 9 - 1857

7. AGE YEARS MONTHS DAYS 69 1 2 18 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St Charles (STATE OR COUNTRY) Mo

10. NAME OF FATHER Herman H. Hackmann

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

12. MAIDEN NAME OF MOTHER Caroline Floetmann

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

14. INFORMANT Emma Knechler (Address) St Charles Mo

15. FILED 3-28, 1927 OTD Beckman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 26 - 1927

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1927, to March 26, 1927. that I last saw h. alive on March 26, 1927, and that death occurred, on the date stated above, at 10:45 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Primary Bronchopneumonia
107A

CONTRIBUTORY (SECONDARY) 100 W (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. No knowledge

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____ WAS THERE AN AUTOPSY? no

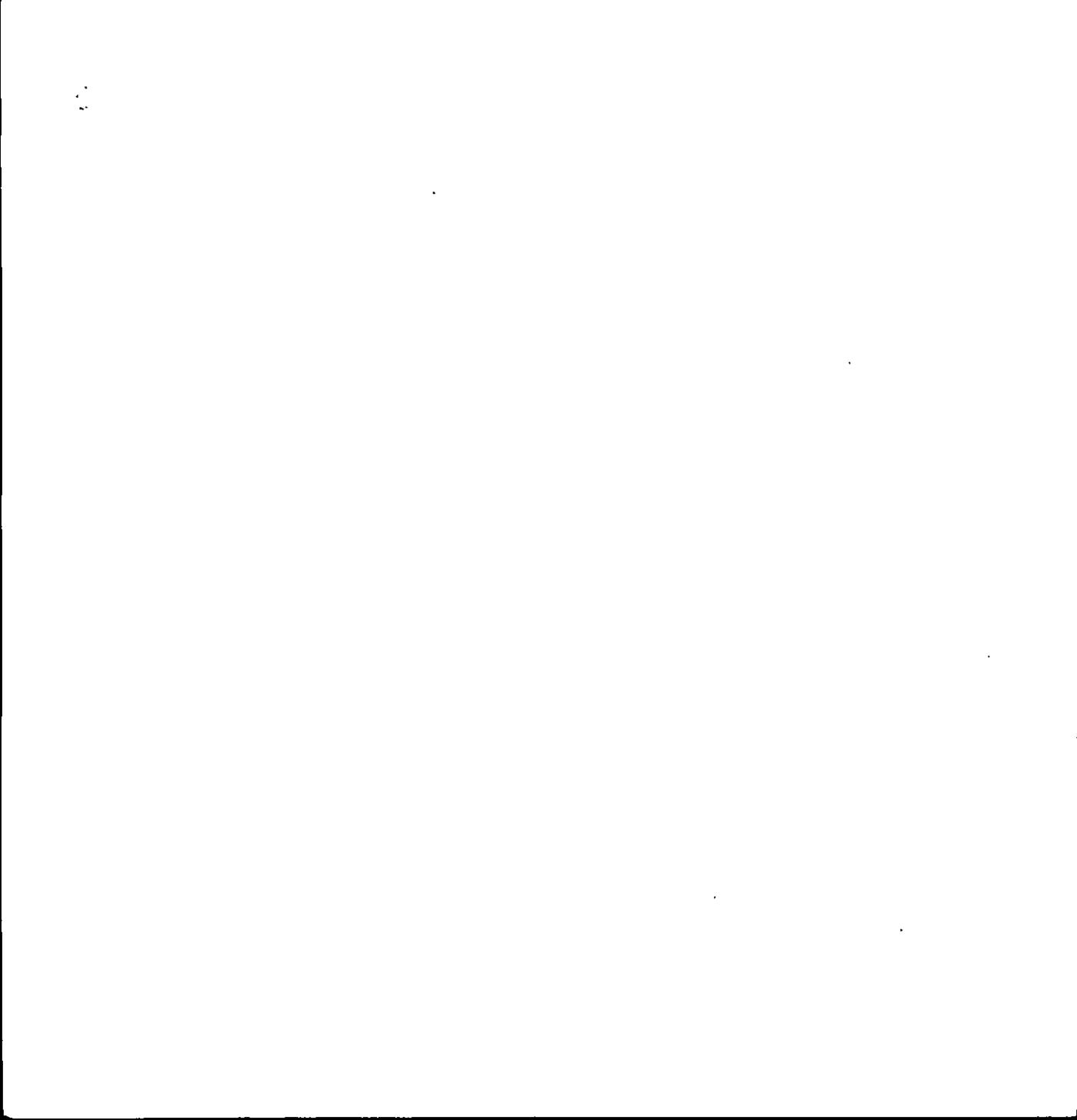
WHAT TEST CONFIRMED DIAGNOSIS Physical Examination (Signed) B. G. Bessard, M. D. March 28, 1927. (Address) 200 Clay St, St Charles Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lutheran Cemetery DATE OF BURIAL March 28 1927

20. UNDERTAKER Steinbricker Fun Co ADDRESS St Charles Mo

PARENTS



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Charles Registration District No. 457 File No. _____
 Township _____ Primary Registration District No. 2036 Registered No. 53
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Carrie Bode

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 9 - 1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
X 70 | 2 | 17 | X

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 5/12 19 27 Oct Bode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 26 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw him _____, _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 _____ (duration) _____ yrs. _____ mos. _____ ds.

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) _____, M. D.
 _____, 19 _____ (Address)

*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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

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

SUPPLEMENTARY

4731-5