

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

Do not use this space.

36349

1. PLACE OF DEATH

County.....Cole..... Registration District No.....213..... File No.....
Township.....Jefferson..... Primary Registration District No.....3014..... Registered No.....322
City.....Jefferson..... (No.....)..... St..... Ward.....

2. FULL NAME Mrs. Josephine Krieger

(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 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 Fred Krieger

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 10, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 6 24

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT A. P. Krieger
(Address) Jefferson City Mo.

15. Filed 12-20-27 J. A. Bedford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1927

17. I HEREBY CERTIFY, That I attended deceased from 10-18, 1927, to 12-4, 1927 that I last saw her alive on 12-4, 1927, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastric Carcinoma
4 1/2 yrs (duration) 1 yrs. 3 mos. 0 ds.

CONTRIBUTORY (SECONDARY) none
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) D. W. Gillham, M. D.

12-5, 1927 (Address) Jefferson City 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 DATE OF BURIAL

River View Cemetery Dec 6 1927

20. UNDERTAKER Wynmore Gordon ADDRESS J E M W

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1927
J. A. Bedford

10/10/2008

**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 Cole
Township Jefferson
City Jefferson (No.)

Registration District No. 213
Primary Registration District No. 9014

File No.
Registered No. 322
St. Ward)

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. 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)

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) Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14.

INFORMANT

(Address)

15.

FILED

12-29-27 S. O. Bedford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 19 27

17. I HEREBY CERTIFY That I attended deceased from

....., 19..... to, 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is req. in percent. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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