

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

Do not use this space.

123778

1. PLACE OF DEATH

County..... *Pettis* Registration District No..... *665*
Township..... *Ledalia* (Primary Registration District No. *3032*)
City..... *Ledalia* (No. *St Mary Hospital*)

File No.....
Registered No. *331*
St. Ward)

2. FULL NAME

Fredericka Brunckhoff

(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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 19 - 1895*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<i>77</i>	<i>8</i>	<i>28</i>		

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 *Fred Plembrek*

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

12. MAIDEN NAME OF MOTHER *Minnie Schmidt*

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

14. INFORMANT *Chris Brunckhoff*
(Address) *Ledalia Mo*

15. FILED *12 25 27* 19 *27*
J. J. Love
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 17 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 30 1927*, to *Dec 17 1927*, that I last saw her alive on *Nov 16 1927*, and that death occurred, on the date stated above, at *5 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

18. Apoplexy -
19 - 20
21 - 6

CONTRIBUTORY *Hypertension & Fracture Femur*
(SECONDARY) *Fracture*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF

20. WAS THERE AN AUTOPSY? *No*

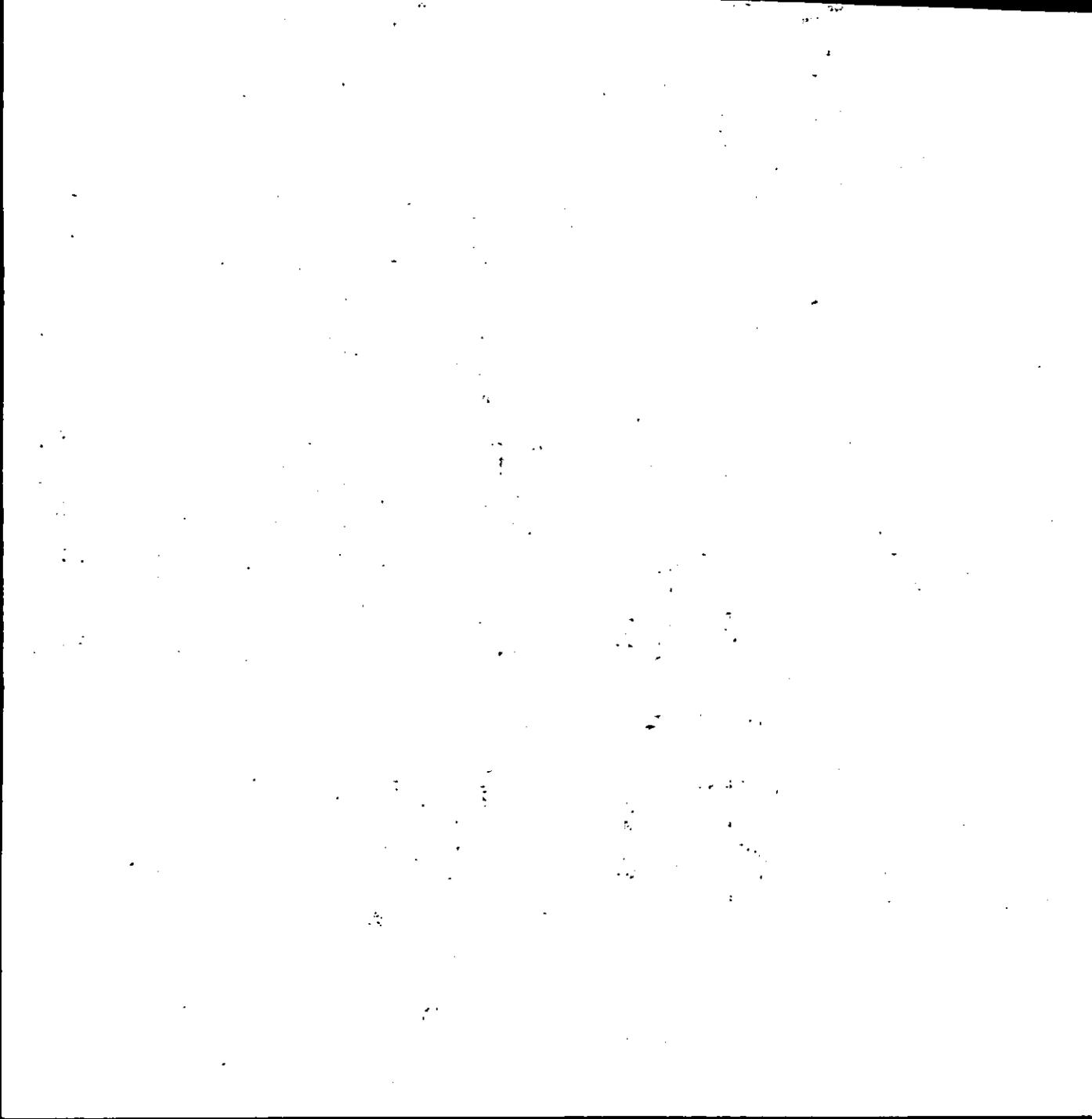
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *D. P. Dyer*, M. D.
, 19 (Address) *Ledalia, Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Ledalia, Mo.* DATE OF BURIAL *Dec 20 1927*

20. UNDERTAKER *Fillepi* ADDRESS *Ledalia*

PARENTS



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pettis Registration District No. 668 File No. _____
 Township _____ Primary Registration District No. 3032 Registered No. 331
 City Bedalia (No. _____) St. _____ Ward _____

2. FULL NAME

Gredeuca Brunckhart
 (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 _____ 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) _____

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 12-28-27

J. L. Lora
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 17 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
Injury due to a fall
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY hypertension & fractured femur
 (SECONDARY) (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

19

20. UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

73778-5