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

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.

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

1. PLACE OF DEATH
County: Warren — Registration District No.: 881 — File No.: 26243
Township: Camp Branch — Primary Registration District No.: 6175 — Registered No.: 28
City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: Caroline Amelia Preus
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: Chas. Preus
6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 20 – 1862
7. AGE: Years 66 — Months 1 — Days 21 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ..... (duration) ..... yrs. ..... mos. 6 ds.
(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeping
(c) Name of employer: ..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): None
9. BIRTHPLACE (CITY OR TOWN): ..... (STATE OR COUNTRY): Germany

PARENTS
10. NAME OF FATHER: Christian Siekmann
11. BIRTHPLACE OF FATHER (CITY OR TOWN): ..... (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Amelia Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): ..... (STATE OR COUNTRY): Germany

14. INFORMANT: Geo. Siekmann
(Address): Alta Vista, Iowa

15. FILED July 13, 1928 — A. W. Ebeling, per F. H. Vahle — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 11 1928
17. I HEREBY CERTIFY, That I attended deceased from July 5, 1928, to July 11, 1928, that I last saw her alive on July 11, 1928, and that death occurred, on the date stated above, at 8-45 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Haemorrhage.
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) Dr. C. L. Drumert, M. D.
July 11, 1928 (Address) Trenton, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: German M. E. Cemetery — DATE OF BURIAL: July 13 1928
20. UNDERTAKER: W. Dixon — ADDRESS: Bethany Mo.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

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

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

City..... (No.....; .....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 | 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) 19

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:

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

CONTRIBUTORY.....
(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. (See reverse side for additional space.)

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

WRITE PLAINLY, WITH UNFADING INK. [illegible]

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