

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

Do not use this space.

21011

1. PLACE OF DEATH

County Clinton
Township Plattsburg
City Plattsburg (No.) St. Ward)

Registration District No. 207
Primary Registration District No. 4126

File No. 17
Registered No. 1719

2. FULL NAME Mrs Carrie C. Wiener

(a) Residence. No. St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (widowed)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 16 - 1843

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
86 | 6 | 1

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER William Trumble

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

12. MAIDEN NAME OF MOTHER Margaret Fry

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

14. INFORMANT J. Wiener
(Address) Plattsburg Mo.

15. FILED 6/18 1929 J. H. Haskin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1929, to June 16, 1929 that I last saw her alive on June 16, 1929, and that death occurred, on the date stated above, at 1 - P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Inaction from refusal of food sufficient food

162 yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) 164 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) P. M. Stockman M. D.
June 17 1929 (Address) Plattsburg 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 Greenlain Cent DATE OF BURIAL June 18 1929

20. UNDERTAKER J. Wiener ADDRESS Plattsburg Mo.

TE PLANNY, WITH SING INK---THIS IS A PERMANENT RECORD

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.

41-29-285
2-2-285
2-2-285
2-2-285
2-2-285

STATE OF NEW YORK
IN SENATE
January 14, 1914.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN ANSWER TO A RESOLUTION PASSED BY THE SENATE
MAY 17, 1912.
ALBANY: JAMES BROWN PUBLISHING CO., 1914.

**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 Clinton Registration District No. 207 File No. 17
 Township _____ Primary Registration District No. 4126 Registered No. _____
 City Plattsburg (No. _____) St. _____ Ward _____

2. FULL NAME Mrs. Ravie C. Winsa
 (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) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 - 1842

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 6 1

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 9/8/20 W. Haskins
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16 1879

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.

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

20. UNDERTAKER _____ ADDRESS _____

WRITE PLAIN WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

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

SUPPLEMENTARY

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