23 1929

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

Do not use this space.

23707

1. PLACE OF DEATH
County Atchison
Township Clay
City Rock Port
Registration District No. 19
Primary Registration District No. 4013
File No.
Registered No.
(No. St. Ward)

2. FULL NAME Katherine Elizabeth Deuser
(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) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 20-1846
7. AGE Years 83 Months 2 Days 11 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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) Kesse Germany
PARENTS
10. NAME OF FATHER David Knierim
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Martha Klump
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
INFORMANT Mrs Bruce Pates
(Address) St Louis Mo
FILED July 1 1929 Mary J Chamberlain REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July-1- 1929.
17. I HEREBY CERTIFY, That I attended deceased from June Twenty Six (26), 1929, to July First (1), 1929 that I last saw her alive on July 1 — 1929, and that death occurred, on the date stated above, at 3-40 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile Dementia Softening of Brain Tissue.
1866
1926
(duration) 1 yrs. 3 mos. — ds.
CONTRIBUTORY (SECONDARY) Arterio Sclerosis Fractured neck of Femur. 1925 (duration) 5 yrs. — mos. — ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? No-Special Test.
(Signed) Austin McMichael, M. D
July 1, 1929 (Address) Rock Port 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 Greenhill Cemetery
DATE OF BURIAL July 3 1929
20. UNDERTAKER C E Bertram
ADDRESS Rock Port Mo.

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: Atchison — Registration District No.: 19 — File No.:
Township: — Primary Registration District No.: 4013 — Registered No.:
City: Rock Port (No. ..... St. ..... Ward)

2. FULL NAME: Katherine Elizabeth Denner

(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)
F	W	Wid

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)

INFORMANT
(Address)

15. FILED July 1, 1929 Mary J. Chambers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1, 1929

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:

x Fall on Street x
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (SECONDARY) Arteria Sclerosis; Fractured neck of femur.
(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

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

A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

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