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

Do not use this space.

1. PLACE OF DEATH
County Lafayette
Township ~~Dayton~~
City Higginsville (No. ..... St. ..... Ward)

Registration District No. 460
Primary Registration District No. 4274

File No. 25089
Registered No. 52

2. FULL NAME Mrs Mary Opfer

(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 Aug Opfer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 10-1855

7. AGE: Years 73, Months 10, Days ..., If LESS than 1 day, ... hrs. or ..... min.

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) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Fredrick Kostermayer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Do no know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Wm Opfer
(Address) Higginsville Mo

15. FILED 7/10, 1929 Bessie P Porter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 10th 1929

17. I HEREBY CERTIFY, That I attended deceased from ~~July 1st~~ July 1st, 1929, to July 10th, 1929, that I last saw her alive on June 8th, 1929, and that death occurred, on the date stated above, at 2 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Bronchitis with Heart block
106B
97
95A
(duration) 30 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteria Sclerosis & Inanition (duration) Do not know 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? Physical
(Signed) [signature], M. D
, 19 (Address) Higginsville 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: Evangelical Cem
DATE OF BURIAL: July 12 1929

20. UNDERTAKER: Hoefer & Meinershagen
ADDRESS: Higginsville Mo

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.

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