

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

Do not use this space

30500

1. PLACE OF DEATH
 County Franklin Registration District No. 297
 Township Washington Primary Registration District No. 3016
 City Washington (No. _____) St. _____ Ward _____

2. FULL NAME Adelmina Vocke
 (a) Residence No. 57 Penn St. 2 Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 68 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 89
 St. _____ Ward _____

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 HUSBAND OR (OR) WIFE OF August Vocke
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 19 - 1839
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
90 95 7 19
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housework
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

PARENTS

10. NAME OF FATHER Wm Utman
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany

14. INFORMANT H. J. Vocke
 (Address) Washington, Mo.

15. Sept. 11, 1929 O. L. Munns
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-8- 1929
 17. I HEREBY CERTIFY, That I attended deceased from July 9, 1929 to Sept 8, 1929
 that I last saw him alive on Sept 6, 1929, and that death occurred, on the date stated above, at 9:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture neck of femur - 1912
abdominal tumor (duration) yrs. 2 mos. 1 ds.
 CONTRIBUTORY Cirrhosis of liver, Malacard liver
 (SECONDARY) Fracture of humerus, (Fracture of humerus) 3 mos. 2 wks. 3 wks.
tumor & abscess of liver (duration) _____ 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? _____
 (Signed) W. May M. D.
9-11- 1929 (Address) Washington, 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 St. Peter's Ceme DATE OF BURIAL Sept 11, 1929
 20. UNDERTAKER Neuberg & Co., Washington, Mo. ADDRESS _____

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin Registration District No. 297 File No. _____
Township _____ Primary Registration District No. 3016 Registered No. 89
City Washington (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 M 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) _____

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 Sept. 11, 1929 O. L. Munch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8 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:
Fracture of femur
caused by stumbling
over door sill (fall)
(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 _____

IS PRESCRIBED BY LAW
CERTIFICATE MUST BE WRITTEN ON THIS SUPPLEMENTARY
REGISTRARS SHALL F
GIV
TIFICATES UNTIL THEY ARE C

SUPPLEMENTARY

S. 30500

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