

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

Do not use this space.

1. PLACE OF DEATH
 County Harrison Registration District No. 384
 Township West Plains Mo Primary Registration District No. H 227
 City West Plains Mo St. _____ Ward _____

2. FULL NAME Beulah P Bohrer
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.
 (If nonresident give city or town and State)

File No. 933674
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE wht. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ed C. Bohrer

7. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 27

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>51</u>	<u>5</u>	<u>20</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Salisbury Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER J. F. Posters

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

12. MAIDEN NAME OF MOTHER Mary A. Trent

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

INFORMANT Ed C. Bohrer
 (Address) West Plains Mo

FILED 10-24-29 O. P. Heineich
 REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/12 1929

17. I HEREBY CERTIFY That I attended deceased from Aug, 1927, to 10-12, 1929, that I last saw h. ea alive on 10-12, 1929, and that death occurred, on the date stated above, at 8:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Sigmoid
46C
46D/15
53B/15 (duration) 2 yrs. mos. da.
 CONTRIBUTORY metastases to colon, rectum,
 (SECONDARY) bladder. (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH:

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 10-7-27

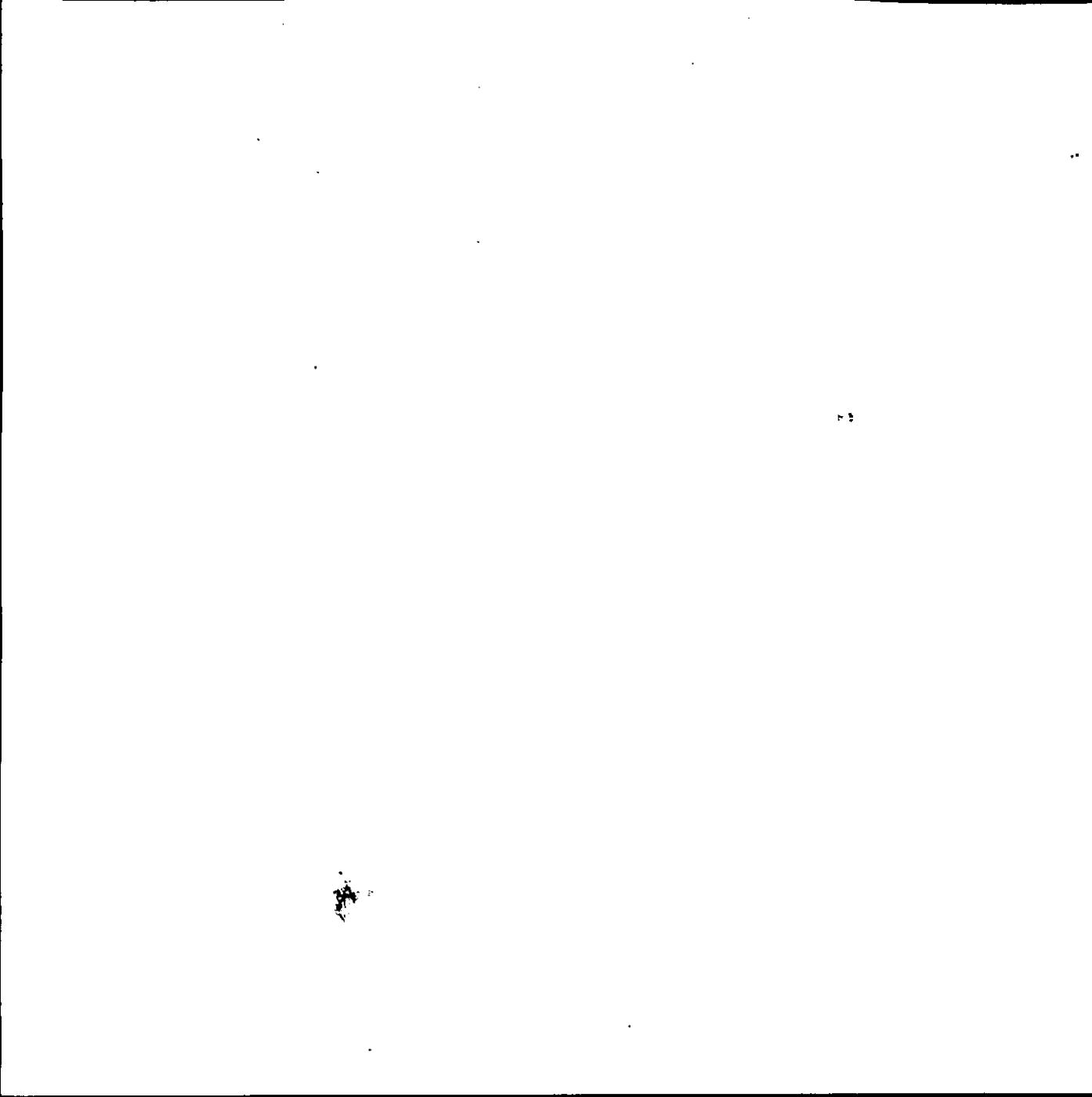
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray
 (Signed) E. Claude Bohrer, M. D.
10-18-29, 1929 (Address) West Plains, 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 Oak Lawn Care, DATE OF BURIAL 10-15-29

20. UNDERTAKER McFarland S ADDRESS West Plains



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Joswell Registration District No. 3874 File No. _____
 Township _____ Primary Registration District No. 4227 Registered No. 97
 City West Plains (No. _____) St. _____ Ward _____

2. FULL NAME

Bessie O. Bohmer
 (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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 22 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 5 20

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 10-24-29 O. P. A. Heinrich
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 - 1929

17. I HEREBY CERTIFY That I attended deceased from _____
 to _____, 19____,
 that I last saw him alive on _____, 19____, and that
 death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. ds. _____
 (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

S-33604