

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

Do not use this space.

36437

**1. PLACE OF DEATH**

County Buchanan Registration District No. 85  
Township \_\_\_\_\_ Primary Registration District No. 1001  
City St. Joseph (No. Missouri Methodist Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 1360

**2. FULL NAME Marie Herbold**

(a) Residence. No. Stop 10 Savannah Int. 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 Male 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 Frank Herbold

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2, 1894

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|--------|-------|--------|------|--|
|        | 35    | 5      | 24   |  |

**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) St. Joseph  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Frank Langemach

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

12. MAIDEN NAME OF MOTHER Louise Rumpf

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

14. INFORMANT Mr. F. J. Langemach  
(Address) Stop 10 Savannah Int.

15. FILED NOV 27 1929 19 John G. [Signature] REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 26 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Nov 26, 1929 that I last saw h. OK alive on Nov 28, 1929, and that death occurred, on the date stated above, at 1/35 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute dilatation of  
139C Stomach  
118C

(duration) \_\_\_\_\_ yrs. mos. 1 ds.

**CONTRIBUTORY (SECONDARY)**

Hysterectomy  
Sibous Metritis  
(duration) \_\_\_\_\_ yrs. mos. 4 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH Stop 10 Savannah Int

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Nov 21-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) Hustav A. Jan, M. D.

Nov. 26 1929 (Address) Kirkpatrick Bldg

\*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**

Ashland Cemetery

**DATE OF BURIAL**

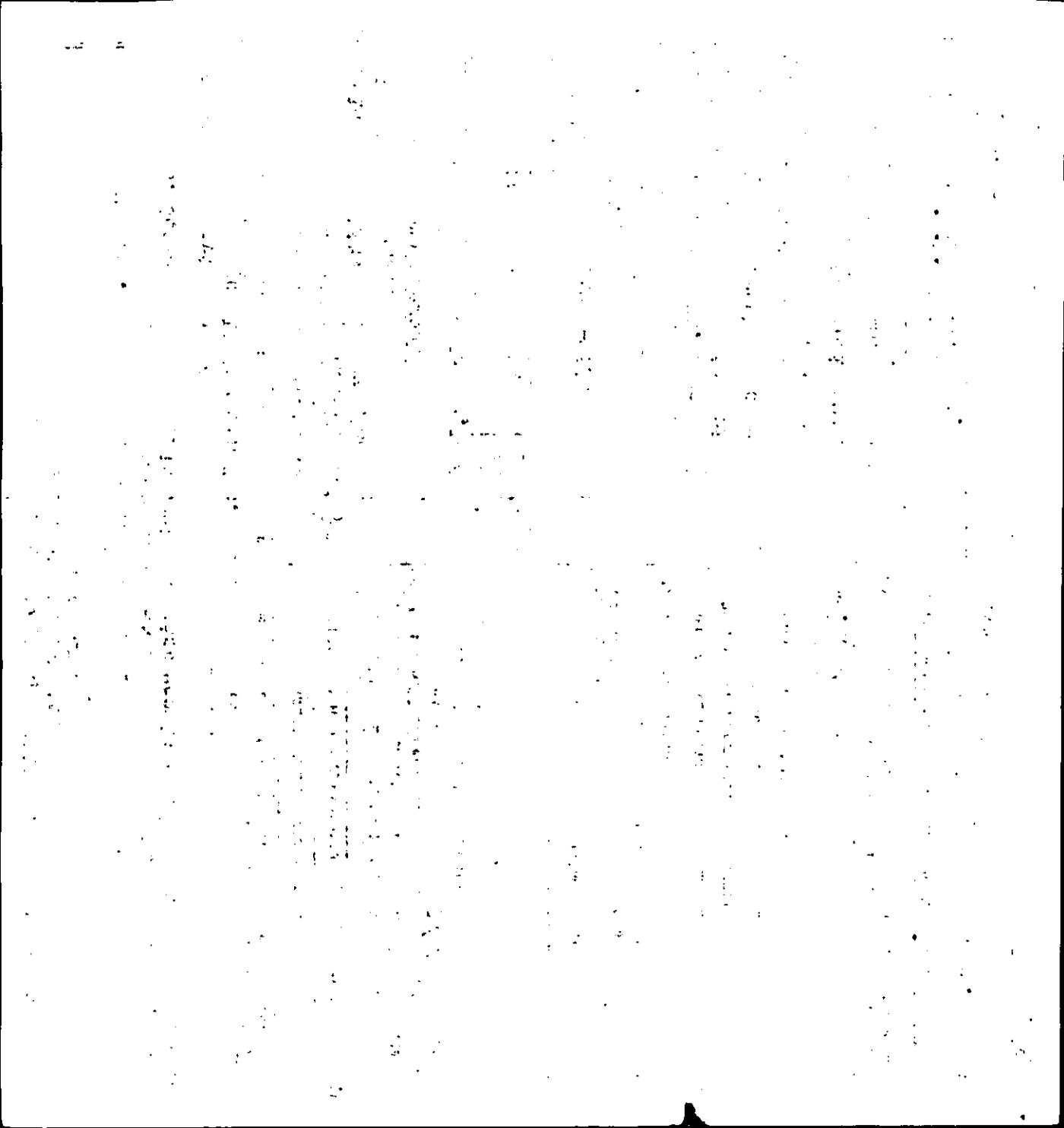
Nov. 28 1929

**20. UNDERTAKER**

H. C. Sidenfaden

**ADDRESS**

1802 Union St.



**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 Puecherson Registration District No. 85 File No. \_\_\_\_\_  
 Township St Joe Primary Registration District No. 1,001 Registered No. 1360  
 City \_\_\_\_\_ (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<br><u>Female</u>  | 4. COLOR OR RACE<br><u>W</u>                               | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)<br><u>W</u> |
| 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) |  |

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 26 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:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Hysterectomy Fibroid  
metritic's (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? 14/10 DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Gustav A. Jan, M. D.  
1/6, 1930 (Address) St. Joseph, 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.

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 1-7 1930 John G. Utz REGISTRAR

|  |                            |
|--|----------------------------|
| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL<br>19 _____ |
| 20. UNDERTAKER                             | ADDRESS                    |

SUPPLEMENTARY

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

S-36437