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

Do not use this space.

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

21 1930

1. PLACE OF DEATH

County Cooper — Registration District No. 218 — File No. 40131

Township — Primary Registration District No. 3015 — Registered No. 137

City Boonville (No. ..... St. ..... Ward)

2. FULL NAME Mrs. Louisa Kaiser,

(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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)
Female	White	Widowed.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 19th 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	79	9	6	

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

2 3

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

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PARENTS

10. NAME OF FATHER Christian Heckerman

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 Mrs. Hy. Wilklemeyer,
(Address) Boonville Mo.

15. FILED Dec 27 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 25 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1929, to Dec 25, 1929 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 12 Noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Complications
Fibrinous Bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Aortic Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? no 106A
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? Not to my knowledge
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) C. H. Reincke, M. D.
, 19 (Address) Boonville, 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	DATE OF BURIAL
Cemetery Cooper Co. Mo. Pleasant Grove Lutheran	12/27 1929
20. UNDERTAKER	**ADDRESS**
Goodman & Boller	Boonville Mo.