

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

Do not use this space.

58

1. PLACE OF DEATH

County Audrain Registration District No. 912
 Township Cypress Primary Registration District No. 222A
 City Naudolia (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 6

2. FULL NAME Mary Christina Remmer

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF John Remmer
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-17-1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 70 5 7

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1930
 17. HEREBY CERTIFY, That I attended deceased from July 7, 1929 to Jan 24, 1930
 that I last saw her alive on Jan 28, 1930 and that death occurred, on the date stated above, at 6:10 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Valvular heart disease (mitral)

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

(duration) 4 yrs yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) _____ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Audrain Co Mo
 (STATE OR COUNTRY) Missouri
 10. NAME OF FATHER Ernst Schreffler
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Wendeham
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY) _____

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) J. M. Mathews, M. D.
 19 (address) Naudolia Mo.

14. INFORMANT Mrs Minnie Schreffler
 (Address) Naudolia Mo
 15. FILED 11/24 1930 Maeie Frew
 REGISTRAR

*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 Naudolia Mo DATE OF BURIAL 1-26 1930
 20. UNDERTAKER J. B. Clark ADDRESS Naudolia Mo

N. B.—Every item on this form should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should file CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

87
 4
 225
 1
 10

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Audrain Registration District No. 912 File No.
 Township Curry Primary Registration District No. 6232 Registered No. 6
 City..... No..... St. Ward)

2. FULL NAME Mary C. Renner
 (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

MEDICAL CERTIFICATE OF DEATH

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) Aug 17-1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 71 X 5 - 7

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
 (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 5/31, 1930 Mallie Fugue REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19....., and that I last saw h..... also 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.

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
 ADDRESS 19

20. UNDERTAKER ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state EXACT OCCUPATION is very important. REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY RECEIVE A FEE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-28