

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

Do not use this space.

4578

1. PLACE OF DEATH
 County Franklin Registration District No. 293
 Township Boles Primary Registration District No. 5411
 City..... (No..... St..... Ward)

2. FULL NAME Anna Marie Plackmann
 (a) Residence. No. Gray Summit St., Mo. Ward.....
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 11 yrs. 10 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 August Plackmann

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 28 - 1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
67 6 0

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) Campbellton
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Hy. Groppe

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

12. MAIDEN NAME OF MOTHER Louise Groppe

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

14. INFORMANT Mrs. Miriam Fisher
 (Address) Gray Summit Mo

15. FILED Mar 130 Feb. M. Fisher
 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1930 to Feb. 27, 1930 that I last saw her alive on Feb. 27, 1930, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
10 1/2 hrs
 (duration) yrs mos ds.

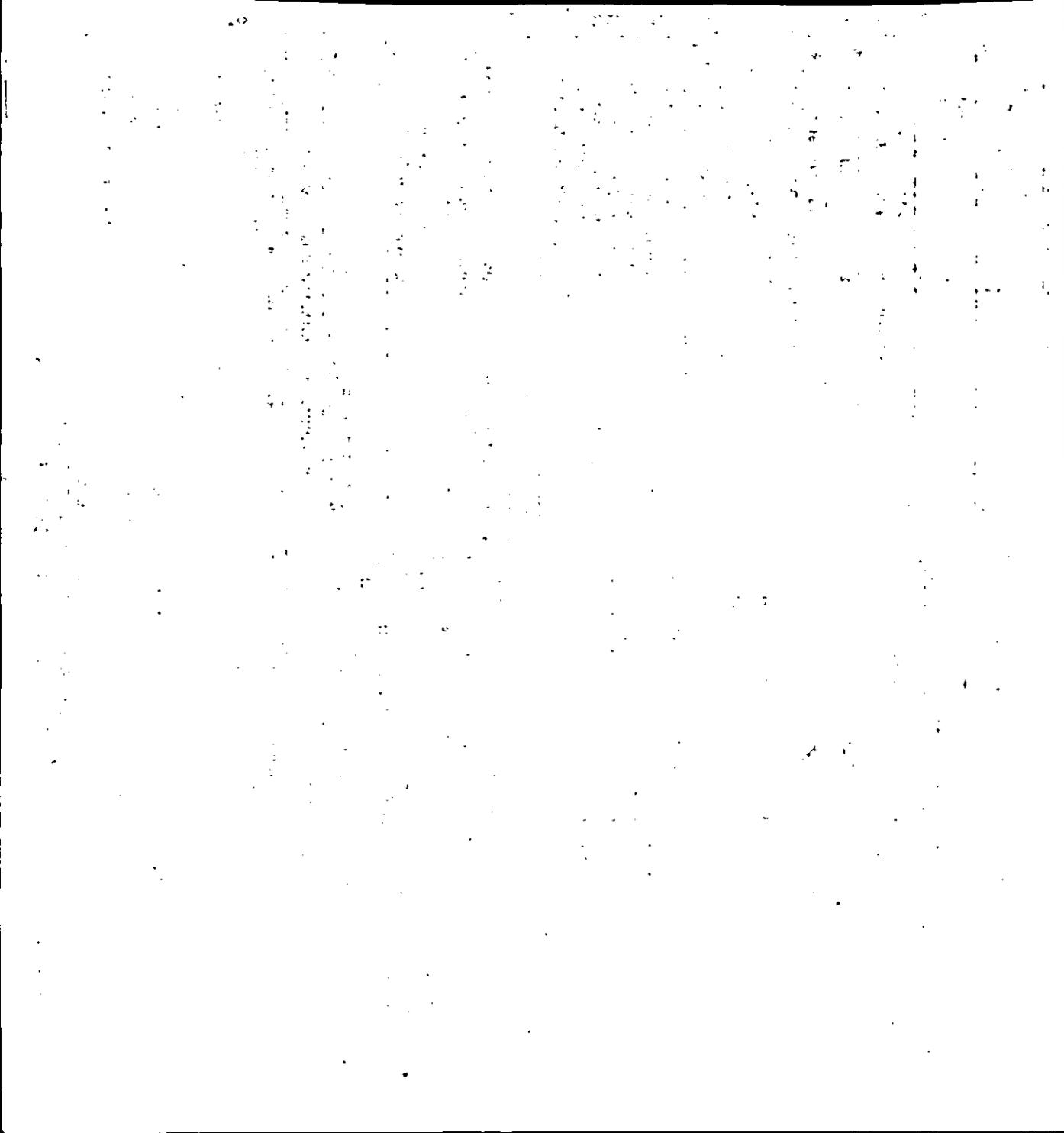
CONTRIBUTORY (SECONDARY)..... (duration) yrs mos ds.

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) W. A. Fisher M. D.
Feb. 28, 1930 (Address) Gray Summit Mo

*State the DISEASE CAUSING DEATH, or if 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 Lutheran Cem. Wash. DATE OF BURIAL 3/2 1930

20. UNDERTAKER Otto & Co. Washington Mo. ADDRESS



**MISSOURI STATE BOARD OF HEALTH
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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. 293 File No. _____
 Township Bales Primary Registration District No. 3711 Registered No. 11
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Anna Marie Plackmann

(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) wid

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 Mar 30 1930 W. H. M. High
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1930

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:

Pneumonia
Broncho

CONTRIBUTORY (SECONDARY) 100% (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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIF. ES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

8L94-S