MAR 28 1930

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

Do not use this space.

6112

1. PLACE OF DEATH St. Joseph Hospital.
County St. Charles, Registration District No. 757
Township St. Charles, Primary Registration District No. 3036
City St. Charles (No. ..... St. ..... Ward)
File No. .....
Registered No. 23

2. FULL NAME Jennie May Otten,
(a) Residence. No. 412 Monroe St., St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 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*): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 12, 1883

7. AGE: Years 47 | Months 9 | Days --- | If LESS than 1 day, ... hrs. or ..... min.

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) Glenn's Falls,
(STATE OR COUNTRY) New York.

PARENTS
10. NAME OF FATHER John Freeman.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Glenn's Falls
(STATE OR COUNTRY) New York.
12. MAIDEN NAME OF MOTHER Elvira ----
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Glenn's Falls
(STATE OR COUNTRY) New York.

14. INFORMANT John J. Otten.
(Address) 412 Monroe St.

15. FILED 2/14, 1930 Ny. G. Bloebaum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1928, to Feb. 12, 1930, that I last saw her alive on Feb. 12, 1930, and that death occurred, on the date stated above, at 9 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Uterus
4 3
4 6
(duration) 1 yrs. 7 mos. 2 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH No knowledge -
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical exam.
(Signed) G. Gene H. Sonnen, M. D.
Feb. 12, 1930 (Address) 200 Clay St St Charles, 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 Grove Cemetery
DATE OF BURIAL: Feb. 15, 1930.

20. UNDERTAKER: Steinbrinker Furn. Co.
ADDRESS: St. Charles, Mo.

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 St Charles — Registration District No. 757 — File No.
Township — Primary Registration District No. 3036 — Registered No. 23
City " " (No. , St. Ward)

2. FULL NAME Jennie May Otten

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 12-1883

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	46	3	—	

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 7/14, 1930 Wm. G. Blackburn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/12, 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:

(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) , 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

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