

NOV 3 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

31821

1. PLACE OF DEATH

County Schuyler
 Township Fabius
 City Leona (No. Frances)

Registration District No. 802
 Primary Registration District No. 6046

File No.
 Registered 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7th 1906.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
24 3 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lancaster, (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Levi Aeschliman.

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

12. MAIDEN NAME OF MOTHER Mary Frances Westhoff.

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

14. INFORMANT Levi Aeschliman. (Address) Lancaster, Mo.

15. FILED 10-11-1930 JRB Bridges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1930 to Sept 15 1930 that I last saw him alive on Sept 15 1930 and that death occurred, on the date stated above, at 7 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs
23A (duration) 5 yrs. 4 mos. 4 ds.

CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. ds.

18. WHERE DISEASE CONTRACTED

* IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Ex. Aut.

(Signed) Francis J. ... M. D.

, 19 (Address) Bloomington, Ill.

*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 Darby Cemetery, DATE OF BURIAL Sept 17 1930

20. UNDERTAKER John A Roberts. ADDRESS Lancaster Mo

old state
important

N. B. CAUSE

35

[illegible]

**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 Cherokee
Township Galbreath
City Leona (No.)

Registration District No. 802
Primary Registration District No. 6046

File No. 31821
Registered No. St. Ward

2. FULL NAME

Leona Frances Aeschliman

(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 S (write the word)

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 10-4-1934 Bridges
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 ,
that I last saw him 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

20. UNDERTAKER ADDRESS

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

REGISTERED BY LAW

5-31821