

NOV 21 1930

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

Do not use this space.

32290

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 125
Township Elape Primary Registration District No. 3009
City Cape Girardeau No. St. Mo. Hospital St. _____ Ward _____

File No. _____
Registered No. 545
St. _____ Ward _____

2. FULL NAME

Marjorie Lucille Gockel
(a) Residence. No. _____ St. _____ Ward. Jackson Mo.
(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 7 4. COLOR OR RACE W 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) March 18, 1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
18 7 13

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. School Girl ^{13.}
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jackson
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Bernhard Gockel

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

12. MAIDEN NAME OF MOTHER Freda Helmreich

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

14. INFORMANT Miss Bess Gockel
(Address) Jackson Mo.

15. FILED 11/1 30 W. K. Kauffman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 19 30

17. I HEREBY CERTIFY That I attended deceased from 10/20 to 10/31 1930
that I last saw her alive on 10/15 1930 and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Head Injure

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Epilepsy & Laceration
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

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 Bleeds
(Signed) C. H. Seabright M. D.
, 19 (Address) Cape Girardeau 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 Russell High's Cemetery DATE OF BURIAL 11/2 19 30

20. UNDERTAKER McComb's Funeral Co. ADDRESS Jackson Mo.

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important.

may be property class, fed. Exact statement of OCCUPATION is very important. Fully supplied. ACR should be stated EXACTLY. OCCUPATION should state

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cape Girardeau
Township _____
City 11 (No. _____)

Registration District No. 125
Primary Registration District No. 2009

File No. _____
Registered No. 543
St. _____ Ward _____

2. FULL NAME

Marjorie Lucille Gockel

(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 (after 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 12/6/30 W. Kaupfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 19 30

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 _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

High Degree Burns
from cleaning clothes in bathroom
at home where she roomed
with naphtha gas
explosion of gasoline
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. OCCUPATIONS should state USE OF DEATH in plain terms, and may be properly classified. Exact statement of OCCUPATION is very important.

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

SUPPLEMENTARY

5-32290