

NOV 26 1930

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

Do not use this space.

33578

1. PLACE OF DEATH

County *Moultrie*
Township *Haller*
City *California* (No. St. Ward)

Registration District No. *571*
Primary Registration District No. *4335*

File No.
Registered No. *57*

2. FULL NAME

Rena Messerli

(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

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

June 24 - 1864

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>66</i>	<i>3</i>	<i>17</i>	

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)

(STATE OR COUNTRY) *Switzerland*

10. NAME OF FATHER

Jacob Burk Haller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Switzerland*

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Switzerland*

14. INFORMANT

(Address) *Herman Messerli*
1111 N. 1st St. Mo

15. FILE

Oct 13 1930
Jacob Roth
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-11-1930* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from *June 1930* to *June 20, 1930* that I last saw her alive on *June 20, 1930*, and that death occurred, on the date stated above, at *10:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Creeping Paralysis

(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? *No.* DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Dr. W. W. Boush* M. D.

10-13, 1930 (Address) *California 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

DATE OF BURIAL

Evangelical Cemetery *10/13 1930*

20. UNDERTAKER

ADDRESS

Mulleau & Friedman *California*

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 is very important.

