

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

Do not use this space.

39958
4966

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Law Primary Registration District No. _____
City Keosauqua (No. Memorial Hosp.) _____

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

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward Rule, Neb.
(Usual place of abode)

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.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 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) Blank

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Blank
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Blank 31

MOTHER / FATHER
13. NAME Blank
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Blank
15. MAIDEN NAME Blank
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Blank

17. INFORMANT Marie Williams (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Falls City, Mo. DATE 12-26 1932

19. UNDERTAKER Carroll - Davidson (ADDRESS)

20. FILED 12-25, 1932 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 24, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw her alive on 24, 24, 1932. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of cervix
metastatic
to lungs
and bones
Other contributory causes of importance:
hemorrhagic anemia

Name of operation none Date of _____
What test confirmed diagnosis? Biopsy Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Robert Koritschauer, M. D.
(Address) 211 E. 68th Ter

WITH UNFADING INK--THIS IS A PERMANENT RECORD

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

