

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

Do not use this space.

26113

1. PLACE OF DEATH

County Franklin Registration District No. 297
 Township Washington Primary Registration District No. 3016
 City Washington (No. _____) St. _____ Ward _____

File No. _____

Registered No. 58

2. FULL NAME Catherine Pues

(a) Residence, No. 630 South Cedar St., _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 0 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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Pues

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1st, 1845

7. AGE YEARS 88 MONTHS 3 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housework
 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) Germany

FATHER 13. NAME Gerhardt Fenger

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Anna Bogemann

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Henry Pues (ADDRESS) 630 South Cedar St., Washington,

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic Cemetery DATE Aug. 24, 1933

19. UNDERTAKER Otto & Co., (ADDRESS) Washington, Mo.

20. FILED Aug 23, 1933 O. L. Munch Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 21, 1933

22. I HEREBY CERTIFY, That I attended deceased from July 11, 1933 to Aug 21, 1933
 I last saw her alive on Aug 21, 1933 Death is said to have occurred on the date stated above, at 1:30 P. M.

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

Emphysema Date of onset _____
1868
1943
1962
1869
 Other contributory causes of importance:
fracture of femur
right hip

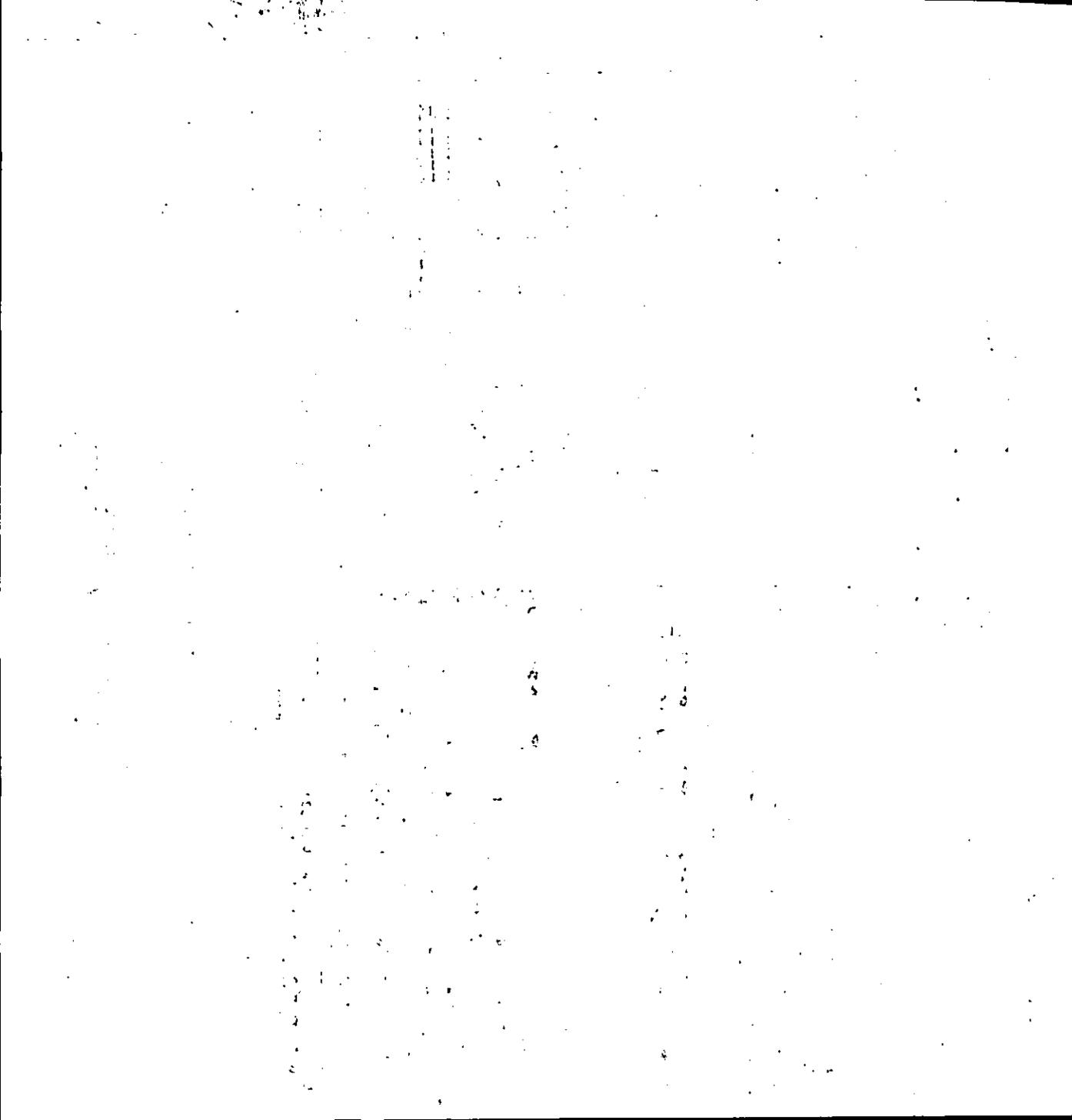
Name of operation None Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? No

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. Home

Manner of injury Fell on her own bath-tub at
 Nature of injury fract. hip Home

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____

(Signed) B. R. Culler M. D.
 (Address) Washington Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin
Township
City Washington (No.)

Registration District No. 297
Primary Registration District No. 3016

File No. 26113
Registered No. 58
St. Ward)

2. FULL NAME Catherine Pius

(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 W (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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
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)

MOTHER FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 19 1933 H. A. May Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 21 1933

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
I last saw h..... alive on....., 19..... 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:

Exhaustion Date of onset

Other contributory causes of importance:
Contra-cerebral fracture right ribs due to fall from the floor in her home (bathroom)
Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....
If so, specify.....
(Signed)....., M. D.
(Address).....

SUPPLEMENTARY

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

S-26113