WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

29525

1. PLACE OF DEATH
48 County Jackson — Registration District No. 398 — File No.
5 Township Blue — Primary Registration District No. 30-19 — Registered No. 297
City Independence (No. Indep. Sanitarium St. Ward)

2. FULL NAME Eva Marie Herman.
(a) Residence, No. 1140 S. Hocker St., Indep. Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 4 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) Married.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 17-1902

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
31	3	01	

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

FATHER
13. NAME Ed Gill.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER
15. MAIDEN NAME Lettie May Hirst
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa.

17. INFORMANT (ADDRESS) August B. Herman 1140 S. Hocker

18. BURIAL, CREMATION, OR REMOVAL
PLACE Woodlawn Cem. DATE Sep 20 1933

19. UNDERTAKER (ADDRESS) Ott & Mitchell Independence Mo.

20. FILED Sept. 19, 1933 Dr. F. L. Cook Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 18, 1933

22. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1933, to Sept. 18, 1933
I last saw her alive on Sept. 18, 1933. Death is said to have occurred on the date stated above, at 5 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cystic Degeneration	
Left ovary	
Uterine Retroversion	
139 B	
55 A	
Other contributory causes of importance: Pulmonary Embolism	9/18/33
111 A	

Name of operation Loophorectomy, Resection tubes (bilat.), Uterine Fixation Date of 9/9/33
What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 9/18, 1933
Where did injury occur? Independence Mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Hospital
Manner of injury Unknown
Nature of injury Pulmonary Embolism

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Chas. F. Trobeke, M. D.
(Address) Independence Mo.