

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

Do not use this space.

39752

1. PLACE OF DEATH
 County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 880
 City Springfield (No. Baptist Hospital) St. _____ Ward) _____
 2. FULL NAME Lena Thumser
 (a) Residence, No. Lockwood Mrs 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED WIDOWED (OR) WIFE OF J. G. Thumser
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 3, 1861
 7. AGE YEARS 72 MONTHS 1 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
 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) Germany

MOTHER FATHER 13. NAME Nehrkamp

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

15. MAIDEN NAME Do not know

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

17. INFORMANT Ray Caldwell (ADDRESS) Lockwood Mrs

18. BURIAL, CREMATION, OR REMOVAL PLACE Loganswood DATE 12-14 1933

19. UNDERTAKER (ADDRESS) Ray Caldwell
Lockwood Mrs

20. FILED 12/13/33 19 Robert Danaston Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 12 1933
 22. I HEREBY CERTIFY, That I attended deceased from Dec 12 1933 to Dec 12 1933
 I last saw her alive on Dec 12 1933. Death is said to have occurred on the date stated above, at 8:20 p.m.
 The principal cause of death and related causes of importance were as follows:

Strangulated Hernia Femoral Date of onset Dec 10 1933
12 hrs

Other contributory causes of importance: _____
 Name of operation sharp Releasing hernia Date of 12-12-1933
 What test confirmed diagnosis? Clouse 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) O. B. Horst M. D.
 (Address) Madison Ave Hwy Springfield

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.

JAN 26 1934
 1933

19
 19
 19

Ray Caldwell
Lockwood Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No.

Township

Primary Registration District No. 2001

Registered No. 880

City Springfield (No. 1001)

Baptist Hospital

Ward)

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 12, 1933

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

22. I HEREBY CERTIFY, That I attended deceased from

to, 19....., 19.....
I last saw h..... alive, 19..... Death is said

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

to have occurred on the d..... at..... m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

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

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)

Date of onset

11. Total time (years) spent in this occupation

Other contributory causes of importance:

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

13. NAME

Name of operation Date of

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

What test confirmed diagnosis? Was there an autopsy?

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide? Date of injury, 19.....

17. INFORMANT (ADDRESS)

Where did injury occur? (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE DATE 19.....

Manner of injury

Nature of injury

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed), M. D.

20. FILED 19..... Registrar

(Address)

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

SUPPLEMENTARY

S-39752