

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

Do not use this space.

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File No. _____
Registered No. 18 _____
St. _____ Ward _____

1. PLACE OF DEATH
County St. Francois Registration District No. _____
Township St. Francois Primary Registration District No. _____
Near Farmington, Mo. (No. _____ St. _____ Ward _____)

2. FULL NAME Josephine Dascher
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
49 ? ?

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26-34
22. I HEREBY CERTIFY, That I attended deceased from 1-24-34 to 1-26-34
I last saw h. er. alive on 1-26-34 Death is said to have occurred on the date stated above, at 10:00 am
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. Housework
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) St. Louis Mo.

Chronic myocardial with Cor. a. 34 hypertrophy & a. 036 dilation 050
Other contributory causes of importance: Syphilis - tertiary & epilepsy with papilloe

13. NAME Unknown 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
15. MAIDEN NAME Unknown 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
17. INFORMANT (ADDRESS) Hospital Records Farmington, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Pond, Mo. DATE 1-28-34
Shhrader Undertaking, Co.
19. UNDERTAKER (ADDRESS) Ballwin, Mo.
20. FILED Jan 27 1934 J. J. Robinson Registrar.

Name of operation None Date of _____
What test confirmed diagnosis? None & Lab Date of _____
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) St. Mary's _____, M. D.
(Address) Hardy

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.

OCCUPATION
FATHER
MOTHER

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