

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

Do not use this space.

21018

1. PLACE OF DEATH

53 County Laurance Registration District No. 472
Township Stott City Primary Registration District No. _____
City Stott City (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____
St. _____ 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

3. SEX <u>M</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wife of C. F. Bekemeier</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar 5th 1860</u>		
7. AGE YEARS <u>74</u>	MONTHS <u>3</u>	DAYS <u>23</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>House Keeper</u>		11. Total time (years) spent in this occupation
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)		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-18 1934

22. I HEREBY CERTIFY, that I attended deceased from June 8th 1934, to June 18th 1934.
I last saw h. alive on June 18th 1934. Death is said to have occurred on the date stated above, at 7 a. m.
The principal cause of death and related causes of importance were as follows:
Postoperative embolism Date of onset 99A
99A ✓
99A

Other contributory causes of importance: _____

Name of operation ventral fixation Date of 6-15-34
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) James O. Beardo
(Address) Wesomca

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

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT C. F. Bekemeier
(ADDRESS) Stott City Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Waltham Ill DATE 6-28 1934

19. UNDERTAKER Phillips & Fossett
(ADDRESS) Wesomca Mo.

20. FILED 7/2 1934 Thos H. Powell
Registrar.

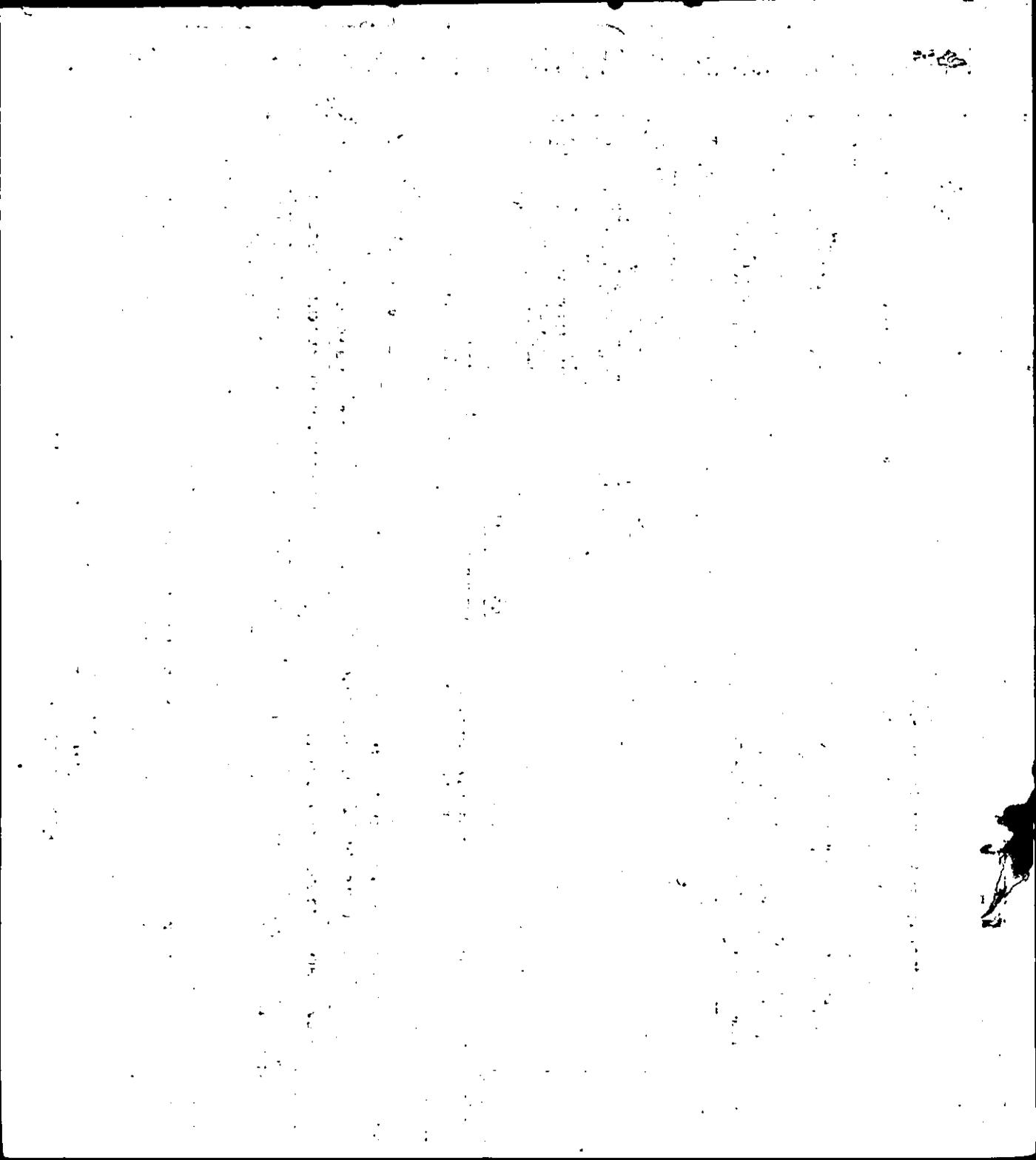
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUL 13 1934

MOTHER FATHER 10 10 10

TMO



#2

Lawrence

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

21018-

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Sapha Bekemeier
Who died at _____ on June 18-1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 74 Months 3 Days 3

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Post-operative on balloon Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____

(Signature of Registrar) Thos. H. Powell Date filed 7-2-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 472

Very truly yours,

E. T. McLaugh
State Registrar

Primary Reg. Dist. No. 4085

Special Agent.

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