

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

Do not use this space.

1. PLACE OF DEATH

County WASCONADE
Township _____
City HERMANN (No. _____)

Registration District No. 303
Primary Registration District No. 4182

File No. 24053
Registered No. 25
St. _____ Ward _____

2. FULL NAME

LOUISE MARIE ROTH FUCHS

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

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEMALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>SINGLE</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>MAY-5-1875</u>		
7. AGE	YEARS	MONTHS
	<u>59</u>	<u>2</u>
		DAYS
		<u>14</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housekeeper</u>	
	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 _____	

2. MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 19, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 19, 1934, to July 19, 1934.
I last saw her alive on July 19, 1934. Death is said to have occurred on the date stated above, at 4 P. m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage (apoplexy)
Chronic nephritis
Date of onset July 19 1934

Other contributory causes of importance: _____

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

13. NAME JACOB ROTH FUCHS

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

15. MAIDEN NAME MARIA NEID HARDT

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

17. INFORMANT (ADDRESS) Mrs Fred Nekele Hermann, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE HERMANN CITY CEM DATE 7-22-34

19. UNDERTAKER (ADDRESS) HUBO BLUMER HERMANN, MO.

20. FILED 7-20, 1934 Anna K. Reckhoff Registrar

Name of operation None 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? NO
If so, specify _____
(Signed) Dr H. G. Schickhoff, M. D.
(Address) Hermann Mo.

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.

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

AUG 16 1934

10
10

