

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.

NOV 13 1934

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

Do not use this space.

1. PLACE OF DEATH

County Bascomade  
Township Rock  
City..... (No. ....) (Ward) .....

Registration District No. 303  
Primary Registration District No. 5420

File No. 35698  
Registered No. 35

2. FULL NAME

Vera Emma Heissen

(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 ( <u>Write the word</u> ) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 28 1929</u>		
7. AGE	YEARS <u>5</u>	MONTHS <u>3</u>
		DAYS <u>4</u>
		IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	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)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Montgomery Co Mo</u>		
FATHER	13. NAME <u>Geo. P. Heissen</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Rhinecland Mo</u>	
MOTHER	15. MAIDEN NAME <u>Elizabeth Grotewiel</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Americus Missouri</u>	
17. INFORMANT <u>Elizabeth Heissen</u>		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	
<u>Rhinecland Mo</u>	<u>Oct 2 1934</u>	
19. UNDERTAKER <u>Kathmann &amp; Co Mo</u>		
(ADDRESS) <u>Rhinecland, Mo</u>		
20. FILED <u>10-2-1934</u> <u>Annual</u> <u>Rieckhoff</u>		
Registrar		

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 1 1934

22. I HEREBY CERTIFY, That I attended deceased from October 1 1934 to October 1 1934  
I last saw her alive on October 1 1934. Death is said to have occurred on the date stated above, at 2:00 P.M.  
The principal cause of death and related causes of importance were as follows:  
Fracture of skull due to fall  
186A  
1934

Date of onset Oct 1 1934

Other contributory causes of importance:

Name of operation ..... Date of .....  
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 Oct 1 1934  
Where did injury occur? at home  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. at home

Manner of injury .....  
Nature of injury Puncture wound at base of skull

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify .....  
(Signed) J. Heising M. D.  
(Address) Herrmann Mo

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**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 Jacksonade  
Township \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 303  
Primary Registration District No. 5420

File No. \_\_\_\_\_  
Registered No. 35  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Sera Emma Theissen

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
5 3 4

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) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

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

13. NAME \_\_\_\_\_

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

15. MAIDEN NAME \_\_\_\_\_

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

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 2 Annat. Kieckhoff Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 1, 1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Fracture of skull due to fall. While walking on wall of old building fell into basement. Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ 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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) J. J. Wessling, M. D.

(Address) J. Hermann, Mo.

**SUPPLEMENTARY**

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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.

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