

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1935

Copy
Original kept in mail

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

Do not use this space.

1. PLACE OF DEATH
County Marion Registration District No. 547 File No. 43652
Township Mason Primary Registration District No. 3029 Registered No. 342
City Hannibal, Mo. (No. St. Elizabeth Hospital St. _____ Ward _____)

2. FULL NAME Catherine Korenz
(a) Residence, No. 2614 Judson St. St. _____ Ward Alton, Ill.
(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) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
About 54

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 2nd, 1934
22. I HEREBY CERTIFY, That I attended deceased from Nov. 27th, 1934 to Dec. 2nd, 1934
I last saw her alive on Dec. 3rd, 1934 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:

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 _____

Rt. lower lobar pneumonia thrombosis mesentric Date of onset _____
Cholecystectomy
Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

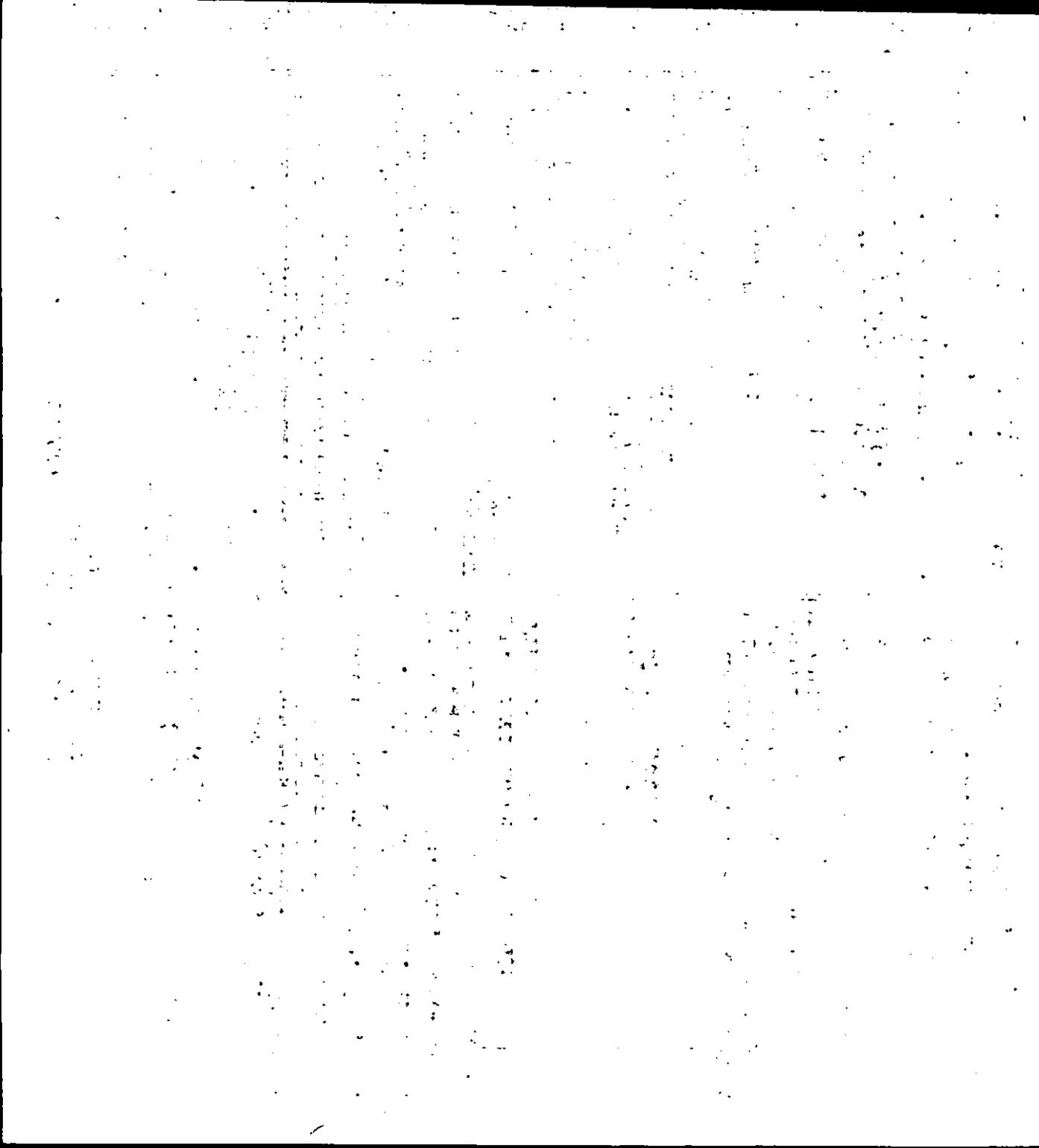
Name of operation Cholecystectomy Date of 11/27/34
What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER FATHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
17. INFORMANT St. Elizabeth Hospital (ADDRESS) Hannibal, Mo.

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 _____

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis, Mo. DATE Dec. 3, 1934
19. UNDERTAKER James O'Donnell, (ADDRESS) Hannibal, Mo.
20. FILED Dec. 3, 1934 B. W. Isbister Deputy Registrar.

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) J. J. Reichmann, M. D.
(Address) Hannibal, Mo.



MAY 14 1935

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1. PLACE OF DEATH

County Marion Registration District No. 547 File No. 43652
 Township Hannibal Primary Registration District No. 3029 Registered No. _____
 City Hannibal (No. St. Elizabeth Hosp.) 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

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 2 1934

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____, 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:

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.
<u>abt</u>	<u>45</u>			

Date of onset

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 _____

Gall Stones,

Other contributory causes of importance:

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

13. NAME

Name of operation Cholecystectomy Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide _____ Date of injury _____ 19____

15. MAIDEN NAME

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

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

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

17. INFORMANT (ADDRESS)

Manner of injury _____

18. BURIAL, CREMATION, OR REMOVAL

Nature of injury _____

PLACE _____ DATE _____ 19____

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

If so, specify _____

19. UNDERTAKER (ADDRESS)

(Signed) _____, M. D.

20. FILED May 9, 1935 E. M. Lucke Registrar (Address) _____

MAY 8 1963

S-43652