

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.

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

Do not use this space.

MAR 27 1935

6252

1. PLACE OF DEATH

County Nodaway Registration District No. 628  
Township Boyer Primary Registration District No. 3031  
City Mayville (No. St. Francis Hospital) 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. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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 _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>12-5-34</u>		
7. AGE YEARS	MONTHS	DAYS
	<u>2</u>	<u>12</u>
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>Conception jet mo</u>		
13. NAME <u>Val G. Weidnerholt</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clyde mo</u>		
15. MAIDEN NAME <u>Mary Bliley</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clyde mo</u>		
17. INFORMANT <u>Val G. Weidnerholt</u>		
(ADDRESS) <u>Conception jet mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Conception jet mo</u> DATE <u>2-19-35</u>		
19. UNDERTAKER (ADDRESS) <u>Conception jet mo</u>		
20. FILED <u>2-18</u> 19 <u>35</u> <u>Mame R. Card</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-17 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 5 1935 to Feb 17 1935  
I last saw h. or w. alive on Feb 17 1935. Death is said to have occurred on the date stated above, at 10:30 a.m.  
The principal cause of death and related causes of importance were as follows:  
Tuberc Pneumonia Date of onset \_\_\_\_\_

Other contributory causes of importance:  
weakened status medic

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical 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. M. Boyles M. D.  
(Address) Conception jet mo

