

MAY 29 1935

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

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13377

1. PLACE OF DEATH

County *Rafayette* Registration District No. *460*
Township *St. Louis* Primary Registration District No. *4274*
City *Higginsville*

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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 26 - 1873*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 7 12

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housekeeper*

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) *Morrison Mo*13. NAME *Fy Siems*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*15. MAIDEN NAME *Elizabeth Fygy*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*17. INFORMANT *John Siems* (ADDRESS) *Higginsville Mo*18. BURIAL, CREMATION, OR REMOVAL PLACE *Evangelical* DATE *4 10 1935*19. UNDERTAKER *Fedger & Meinenhagen* (ADDRESS) *Higginsville Mo*20. FILED *April 10 1935* *9 6 M B*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 8 1935*22. I HEREBY CERTIFY, That I attended deceased from *April 3 1935*, to *April 3 1935*, 19...I last saw her alive on *April 3 1935*. Death is saidto have occurred on the date stated above, at *9:30 a.m.*

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

Pneumonia - Lobar

Date of onset

(Refused medical attention.)

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? *Phys.* 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) *W. C. Brase Klein*, M. D.(Address) *Higginsville 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.



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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 Lafayette
Township _____
City Higginsville (No. _____)

Registration District No. 460
Primary Registration District No. 4274

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

Emma Siems

(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 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) Aug 26 - 1873

7. AGE YEARS 61 MONTHS 7 DAYS 26 If LESS than 1 day, _____ hrs. or _____ min.

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 June 15, 1903 W. G. Webb

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 8, 1903

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 last stated above, at _____ m.

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

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) _____, M. D.

(Address) _____

SUPPLEMENTARY

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

JUN 24 1945

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