

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

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 3 2 1935

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

Do not use this space.

1. PLACE OF DEATH  
County \_\_\_\_\_ Registration District No. **791**  
Township \_\_\_\_\_ Primary Registration District No. **1003**  
City **Othman** (No. **1st Johns A Hospital**) St. \_\_\_\_\_ Ward) **18222**  
Registered No. **4568**

2. FULL NAME **Mabel E Boerner**  
(a) Residence, No. \_\_\_\_\_ St. **NR** Ward. **Columbia 200**  
(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 <b>Female</b>	4. COLOR OR RACE <b>white</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Gustave Boerner</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>May 29 - 1888</b>		
7. AGE	YEARS <b>46</b>	MONTHS <b>11</b>
	DAYS <b>21</b>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>housewife</b>	
	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) <b>Lee</b>		
FATHER	13. NAME <b>John W. Schwartzer</b>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Penna</b>	
MOTHER	15. MAIDEN NAME <b>Lydia Reimer</b>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Laylowville Ill</b>	
17. INFORMANT <b>Gustave Boerner</b> (ADDRESS) <b>Columbia 200</b>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Millstadt Ill</b> DATE <b>5-20 1935</b>		
19. UNDERTAKER <b>Eg. Schneider and Co</b> (ADDRESS) <b>Columbia 200</b>		
20. FILED <b>MAY 22 1935</b> <b>J. Brudeck</b> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5-20 1935**

22. I HEREBY CERTIFY, That I attended deceased from **May-13 1935**, to **May 20 1935**  
I last saw him alive on **May 20 1935**. Death is said to have occurred on the date stated above, at **8:30 a.m.**  
The principal cause of death and related causes of importance were as follows:  
**Scrub typhus**  
**7777**  
**(Submucous throat lesions)**  
Other contributory causes of importance:  
**Submucous throat lesions**  
**2. Non-malignant**  
**Monocytic leukemia**  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? **Leuc** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? **L** Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? **L**  
(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) **J. E. Boerner** M.D.  
(Address) **5-17-26 Columbia 200**

Je 6911