

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.

JAN 16 1936

39208

1. PLACE OF DEATH

County Gasconade
Township Beauff
City (No. _____)

Registration District No. 306
Primary Registration District No. 5424

File No. _____
Registered No. 7
St. _____ Ward _____

2. FULL NAME

Wilhelmina Heidlerink

(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 33 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-13-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 11 24

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. XX

10. Date deceased last worked at this occupation (month and year) 11-3-34 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bay, Mo

13. NAME Peter Bezen

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

15. MAIDEN NAME Not known

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

17. INFORMANT Martin Heidlerink
(ADDRESS) Beaufort, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Larkin Cemetery DATE 12-15-35

19. UNDERTAKER E. J. Meyer
(ADDRESS) Beaufort, Mo

20. FILED 12-13-35 1935 John Engelbush
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 13, 1935

22. I HEREBY CERTIFY That I attended deceased from Dec 12, 1935 to Dec 13, 1935

I last saw hu alive on December 12, 1935. Death is said to have occurred on the date stated above, at 9:00 a.m.

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

Died of acute bronchitis pneumonia
Had been paralyzed on one side for 13 months.

Date of onset 12-10-35

Other contributory causes of importance:

Name of operation None Date of _____

What test confirmed diagnosis? Clinical Was there an autopsy? no

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) H. P. Fitzgerald, M. D.

(Address) Beaufort, Mo.

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

Do not use this space.

1. PLACE OF DEATH

County Gasconade
Township Beaufort
City (No. St. Ward)

Registration District No. 306
Primary Registration District No. 3424

File No.
Registered No.

2. FULL NAME

Wilhelmina Weidner

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
75 11 24

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

Died of acute Broncho Pneumonia 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

Other contributory causes of importance:
Had been paralyzed on one side for 13 months from cerebral hemorrhage

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. UNDERTAKER (ADDRESS)

20. FILED 12-17-1935 John Engelbrecht Registrar

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) W. P. Fitzgerald, M. D.
(Address) Beaufort

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.

SUPPLEMENTARY

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