

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.

DEC 17 1935

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

Do not use this space.

40309

1. PLACE OF DEATH *Miller*  
County *Miller* Registration District No. *6*  
Township *Orange* Registration District No. *5759 W*  
City *Rick Fountain St Elizabeth* St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Mary Beckmeyer*  
(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 *46 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*) *widowed*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 4 1858*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*77 7 19*

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. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation *life*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Rick Fountain Mo.*

MOTHER FATHER  
13. NAME *John Strempf*  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*  
15. MAIDEN NAME *Margaret Fick*  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *John Strempf St Elizabeth*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St Elizabeth* DATE *Dec 26 1935*

19. UNDERTAKER (ADDRESS) *Herman Knapp meta and*

20. FILED *2-27* 1935 *John C. Schreiner* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 23 1935*  
22. I HEREBY CERTIFY, That I attended deceased from *Oct 18 1935*, to *Dec 23 1935*  
I last saw *her* alive on *Dec 23 1935*. Death is said to have occurred on the date stated above, at *11 AM*.  
The principal cause of death and related causes of importance were as follows:

*Apoplexy*  
Date of onset *Oct 18*  
Other contributory causes of importance: *None*

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? *no*  
If so, specify \_\_\_\_\_  
(Signed) *M. H. Johnson* M. D.  
(Address) *St Elizabeth Mo.*

