

SEP 21 1937

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

Do not use this space.

31177

1. PLACE OF DEATH

County Marion Registration District No. 541
Township Jefferson Primary Registration District No. 4321
City Belle mo (No. _____) St. _____ Ward _____

File No. _____

Registered No. _____

2. FULL NAME

Elizabeth M Lindner
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

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 Fred Lindner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 13, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 2 21

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) Franklin Co Mo.

13. NAME Godfrey Gehlest

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

15. MAIDEN NAME Margaret Rapp

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

17. INFORMANT (ADDRESS) E. A. Lindner Belle mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Lobby Camp DATE Aug 6, 1937

19. UNDERTAKER (ADDRESS) J. G. Lickel Belle mo

20. FILED Sept 10, 1937 Mrs. Gertrude Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4, 1937

22. I HEREBY CERTIFY, That I attended deceased from June 29, 1937, to Aug 3, 1937. I last saw her alive on Aug 3, 1937. Death is said to have occurred on the date stated above, at 11:30 a.m.

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

Acute Nephritis
semilitis

Other contributory causes of importance:

Cystitis

Name of operation none Date of _____
What test confirmed diagnosis symptoms 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) Dr. R. Currell, M. D.
(Address) Belle Mo.

Date of onset March
known
May 31

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Marion Registration District No. _____
 (b) Township _____ Primary Registration District No. _____ Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth M Lindner

(a) Residence, No. _____ St. _____
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 2 21

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__

I last saw him _____ alive on _____, 19__ Death is said

to have occurred on the date stated above, at _____ m.

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

acute nephritis

Date of onset

sterility
also had known cause, but made no visit.

Other contributory causes of importance:

Cystitis

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. Ferrell, M. D.

(Address) Belle mo

S-31177