OCT 27 1937

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

Do not use this space.

35462

1. PLACE OF DEATH
County Shannon — Registration District No. 1077 — File No.
Township Casto — Primary Registration District No. 6083 — Registered No. 28
City (No. , St. Ward)

2. FULL NAME Rachel Savene Koller

(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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 24 - 1885

7. AGE YEARS 52 MONTHS 6 DAYS If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home
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) Dent C. Mo.

FATHER
13. NAME Lye Morton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

MOTHER
15. MAIDEN NAME Debora Sparks
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know.

17. INFORMANT (ADDRESS) Frank Koller

18. BURIAL, CREMATION, OR REMOVAL
PLACE Summersville DATE Sept 25 1937

19. UNDERTAKER (ADDRESS) Ole C Rundolph Summersville Mo

20. FILED Sept 25 1937 H. McDaniels M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9 - ~~24~~ 24 3, 1937

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
I last saw her alive on 9 - ~~24~~ 3, 1937 Death is said to have occurred on the date stated above, at 9:30 p.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset

Other contributory causes of importance:

High blood pressure

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) Dr. O M Reeds M. D.
(Address) Summersville

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

35-462

Do not use this space.

1. PLACE OF DEATH
   (a) County Shannon Registration District No. 1077
   (b) Township Carter Primary Registration District No. 6083 Registered No.
   (c) City (d) Street No. , St.
   (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 Rachel Laverne Koller
   (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 (*write* the word): m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 24th, 1885

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

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 Sept 25, 1937 J B McDaniels M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 24, 1937

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 date 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) Dr O. M. Reeds, M. D.
(Address) Summersville Mo

SUPPLEMENTARY

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

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