

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

Do not use this space.

NOV 22 1937

238445

1. PLACE OF DEATH

County Bettis

Registration District No. 665

File No. 285

Township _____

Primary Registration District No. 3032

Registered No. 668

City Sedalia

(No. _____)

Bothwell Hospital

St. _____

Ward _____

2. FULL NAME

Mrs Dick Klink

(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

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

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

4-7-1854

7. AGE

83 YEARS

MONTHS

5

DAYS

27

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)

Germany

FATHER

13. NAME

Claus Meisner

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

Germany

MOTHER

15. MAIDEN NAME

Margaret Harms

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

Germany

17. INFORMANT (ADDRESS)

Mrs Claus Meisner
Tonia, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Holy Cross

DATE 10-6-37

19 _____

19. UNDERTAKER (ADDRESS)

E L Eickhoff
Cole Camp Mo

20. FILED

10/6 1937 Jean Slack Registrar

MEDICAL CERTIFICATE OF DEATH

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

10-4-37 19 _____

22. I HEREBY CERTIFY, That I attended deceased from

Oct 4, 1937, to Oct 4, 1937

I last saw her alive on Oct 4, 1937. Death is said

to have occurred on the date stated above, at 12:20 A.M.

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

General peritonitis caused by ruptured gall bladder

Date of onset _____

Other contributory causes of importance:

Gall stones and diseased bladder

Name of operation Laparotomy Date of 10-4-37

What test confirmed diagnosis? Specimen 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) M.P. Shuff, M. D.

(Address) Sedalia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S signed statement of 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.

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

38445-
Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 668
 (b) Township _____ Primary Registration District No. 30321 Registered No. 285-
 (c) City Sedalia (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

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED un
 (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.
83 5 27

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 10-6 1937 Jean Slack Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-4 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:

General peritonitis caused by a ruptured gall bladder
and stress and
disrupted gall bladder

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) M. S. Slack, M. D.

(Address) Sedalia Mo

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

SUPPLEMENT

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County Jettie Registration District No. 668
 (b) Township Jettie Primary Registration District No. 3032 Registered No. 285-
 (c) City Sedalia (d) Street No. Bathurst Hospital 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 Mrs Anna Klink

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-4-1937

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

22. I HEREBY CERTIFY, That I attended deceased from

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
83 5 27

General Peritonitis
 Caused from a ruptured
 Gall bladder

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

Other contributory causes of importance:
 Gall stones and de-
 eased bladder

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

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

13. NAME

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

15. MAIDEN NAME

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

17. ORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL DATE [], 19[]

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10-6 1937 Jean Slack Local Registrar

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.

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) M. P. Shy, M. D.
 (Address) Sedalia Mo.

PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY.

SUPPLEMENTARY