

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

**41213**  
Do not use this space.

**DEC 17 1937**

**1. PLACE OF DEATH**

(a) County Franklin Registration District No. 297  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3016 Registered No. 89  
 (c) City Washington, Mo. (d) Street No. St. Francis 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 48 yrs. 3 mos. 3 ds. (f) How long in U. S., if of foreign birth?  yrs. mos. ds.

**2. PRINT FULL NAME**

Erna Marie Kossmann  
 (a) Residence, No. 402 East 7th, Washington, Mo. (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Adolph Kossmann</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 8 - 1889</u>		
7. AGE	YEARS <u>48</u>	MONTHS <u>3</u>
	DAYS <u>3</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Home</u>	
	10. Date deceased last worked at this occupation (month and year) <u>11/4/37</u>	11. Total time (years) spent in this occupation
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington, Mo.</u>	
	13. NAME <u>Frederick Butt</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
	15. MAIDEN NAME <u>Charlotte Siskendick</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
	17. INFORMANT <u>Adolph Kossmann</u> (ADDRESS) <u>Washington, Mo.</u>	
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Peter's Ceme</u> DATE <u>11/14/37</u> <u>Washington, Mo.</u>	
	19. FUNERAL DIRECTOR <u>Wickburg &amp; Litt, Inc</u> (ADDRESS) <u>Washington, Mo.</u>	
	20. FILED <u>Nov. 13 - 1937</u> <u>N.A. May</u> Local Registrar	

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 11th 1937

22. I HEREBY CERTIFY, That I attended, deceased from Oct 15 - 1937, to Nov 11 1937

I last saw him alive on Nov 11 1937. Death is said to have occurred on the date stated above, at 7:00 P. m.

The principal cause of death and related causes of importance were as follows:  
Several Papillary Fibroid tumors of uterus not malignant  
 (IX)

Other contributory causes of importance:  
Rarely obstructive (post-operative) following hysterectomy

Name of operation hysterectomy Date of Oct 15, 37  
 What test confirmed diagnosis diagnose 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) R. R. Cretley M. D.  
 (Address) Washington, Mo

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.

12213

STATEMENT BY LICENSED EMBALMER

I, Lester H. Vitt, Licensed Embalmer No. 3254

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed Lester H. Vitt

Licensed Embalmer No. 3254

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

SWISS

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Franklin Registration District No. 297  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3016 Registered No. \_\_\_\_\_  
 (c) City Washington (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 Erna Marie Kossman

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11 1929

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

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:

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
48 3 3

Principal cause of death: General Peritonitis Date of onset \_\_\_\_\_  
Extrenal causes of peritonitis not maligndant

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:  
Cough obstruction (541)  
Post operative following Hep-Pericampfiand systems  
 Name of operating physician \_\_\_\_\_ Date of operation Oct 28 1929  
 What test confirmed diagnosis? clinical Was there an autopsy? Yes

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

FATHER 13. NAME \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 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\_\_\_\_

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) R. R. Cutler, M. D.  
 (Address) Washington Mo

Local Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

