

REG'D SEP 28 1938

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

29736

Do not use this space.

1. PLACE OF DEATH

(a) County Phelps Registration District No. 678
 (b) Township St James Primary Registration District No. 5904
 (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

Mary J Ringeisen
 (a) Residence, No. Jake Prairie Mo. 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 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 John Ringeisen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-24-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
71 2 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home wife
 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) 7-1-1938
 11. Total time (years) spent in this occupation 60 yr

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jake Prairie Mo13. NAME Chas Lucklider14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jake Prairie Mo15. MAIDEN NAME Rebecca Thrift16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jake Prairie Mo17. INFORMANT (ADDRESS) John Ringeisen Cuba Mo18. BURIAL, CREMATION, OR REMOVAL PLACE & DATE Lucklider 8-11 193819. FUNERAL DIRECTOR (ADDRESS) W E Lucklider St James Mo20. FILED 9-1-1938 Elvis B. Houk Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-9 193822. I HEREBY CERTIFY, That I attended deceased from 8-3-1938 to 8-9-1938I last saw him alive on 8-9-1938. Death is said to have occurred on the date stated above, at 5:30 P. m.

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

Acute Myocardial Date of onsetHeart1938

Other contributory causes of importance:

Gangrene of LeftHeart Popliteal ThrombosisName of operation No. Amies Date of ✓What test confirmed diagnosis? Amies Was there an autopsy? ✓

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No Date of injury ✓, 1938Where 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) E. R. Scott M. D.(Address) St James Hospital

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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Do not use this space.

1. PLACE OF DEATH

(a) County Phelps Registration District No. 678
 (b) Township St. James Primary Registration District No. 3904 Registered No. _____
 (c) City _____ (d) Street No. St. James Hospital St. James Mo. X 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. (1) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Mary J. Ringersen 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 (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8 - 9 1938

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.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
71 2 15

acute myo carditis Date of onset

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:
gangrene of right leg due to capillary thrombosis

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

13. NAME

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

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 1-22- 1938

Elsie B. Hous
Local Registrar

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) E. A. Seatt M. D.
 (Address) St. James Hospital
St. James

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

SUPPLEMENTARY

S-29736