

FEB 24 1939

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

2951
Do not use this space.

AGE OF DEATH

(a) County Burlington Registration District No. 508
(b) Township _____ Primary Registration District No. 3026 Registered No. 8
(c) City Chillicothe (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

Emilie Masters
(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 <u>Female</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lehris Masters</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb-19-1871</u> | | |
| 7. AGE | YEARS <u>67</u> | MONTHS <u>11</u> |
| | DAYS <u>12</u> | IF LESS than 1 day, hrs. or min. |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>At Home</u> | |
| | 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) <u>Holstein Germany</u> | | |
| FATHER | 13. NAME <u>Carl Bohmhoff</u> | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u> | |
| MOTHER | 15. MAIDEN NAME <u>Unknown</u> | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u> | |
| 17. INFORMANT (ADDRESS) <u>Lehris Masters Meadville Mo</u> | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Meadville Mo</u> DATE <u>Feb-3-1939</u> | | |
| 19. FUNERAL DIRECTOR (ADDRESS) <u>James D. Gordon Chillicothe Mo</u> | | |
| 20. FILED <u>2-4-39</u> <u>Donald M. Dowell M.D.</u> Local Registrar. | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb-1-1939
I HEREBY CERTIFY, That I attended deceased from Jan 29, 1939, to Feb 1, 1939
last saw h. c. v. alive on Feb 1, 1939 Death is said to have occurred on the date stated above, at 6-P m.

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

Bronchopneumonia Date of onset _____

Other contributory causes of importance:

Fracture of right femur

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury _____, 19____
Where did injury occur? Meadville Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home

Manner of injury Fall on hip
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Donald M. Dowell M. D.
(Address) Chillicothe Mo

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2907
Do not use this space.

1. PLACE OF DEATH
 (a) County Lumpkin Registration District No. 508
 (b) Township Primary Registration District No. 3026 Registered No.
 (c) City Chillicothe (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 Emilie Marters
 (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) wid

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. |
|-----------|-----------|-----------|------|--|
| <u>67</u> | <u>11</u> | <u>12</u> | | |

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. FUNERAL DIRECTOR (ADDRESS)
 20. FILED 19

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1 1939

22. I HEREBY CERTIFY, That I attended deceased from 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:
Bacterial Pneumonia Date of onset 1960
fracture of rt femur
 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? Accident Date of injury 12-27, 1938
 Where did injury occur? Meadville, Mo. (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
In home:
 Manner of injury Fell on side walk in front of
 Nature of injury fracture of rt femur.

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify Donald M. Dowell, M. D.
 (Signed) Chillicothe Mo
 (Address)

SUPPLEMENTARY

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

Local Registrar.

