

REC'D MAR 20 1939

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

7651
Do not use this space.

1. PLACE OF DEATH

(a) County St Charles Registration District No. 913
(b) Township Fernside Primary Registration District No. 5996 B Registered No. 2
(c) City St. Charles (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 MARY TETERS

(a) Residence, No. Mason, 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) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-23-1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
19 3 21

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) St. Charles Co (STATE OR COUNTRY) MoFATHER 13. NAME Ray Teters14. BIRTHPLACE (CITY OR TOWN) Boone Co (STATE OR COUNTRY) MoMOTHER 15. MAIDEN NAME Minnie Mitchel16. BIRTHPLACE (CITY OR TOWN) Howard Co (STATE OR COUNTRY) Mo17. INFORMANT Minnie Teters (ADDRESS) Mason Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Augusta DATE Feb 16, 193919. FUNERAL DIRECTOR (NAME) Morris Muschany (ADDRESS) Howell Mo20. FILED Feb 17, 1939 O R Beeman Local Registrar. 693

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 14, 193922. I HEREBY CERTIFY, That I attended deceased from 1-9-1939 to 2-14-1939I last saw her alive on 2-6-39 Death is said to have occurred on the date stated above, at 1:30 p.m.

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

Date of onset MAR. 1938
Diarrhea & enteritis
Toxemia & Exhaustion

Other contributory causes of importance: 12/10
Colitis Chronic. 1934

Name of operation _____ Date of _____

What test confirmed diagnosis? clinical & Xray 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? _____

If so, specify _____

(Signed) R J Bondke, M. D.(Address) 200 Clay St.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *William W. Neuhoff*

Licensed Embalmer No. *2464*

P. O. Address. *Hamburg*

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.)

If this body is not embalmed, above space should be left blank.