

APR 24 1939

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

9900  
Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Co Registration District No. 26  
(b) Township ..... Primary Registration District No. 3992 Registered No. 34  
(c) City Merico Mo (d) Street No. Andrew 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

Maguire Preul  
(a) Residence, No. Bellflower Mo St.  (If nonresident, give city or town and State)

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 Wm C Preul  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-3-  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
37 4 5  
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. General duties  
10. Date deceased last worked at this occupation (month and year) 1939 Jan 20 11. Total time (years) spent in this occupation.....  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warrensburg Mo  
13. NAME Ed J Fitzgerald  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warrensburg Mo  
15. MAIDEN NAME Mattie M Quinn  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warrensburg Johnson Co Mo  
17. INFORMANT (ADDRESS) Wm C Preul  
Bellflower Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Warrensburg DATE 3-10-39  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. B. Jones  
Bellflower Mo  
20. FILED Mar 8 1939 Blanche Keely  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 8, 1939  
22. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1939, to March 5, 1939  
I last saw him alive on March 5, 1939 Death is said to have occurred on the date stated above, at 6:30 p.m.  
The principal cause of death and related causes of importance were as follows:  
Infected incomplete abortion Date of onset 3/23/39  
General Peritonitis 3/28/39  
Infected incomplete abortion  
Other contributory causes of importance: 170  
Unsuccessful removal  
Name of operation Placenta Date of 3/28/39  
What test confirmed diagnosis? Lab. & Clin. 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) H. D. Walker, M.D.  
22 (Address) Warrensburg, Mo

RECEIVED

District Health Officer No. 10

District File Number. 10-39-541

Date Filed APR 20 1939

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

9900  
Do not use this space.

1. PLACE OF DEATH

(a) County Andrain Registration District No. 26  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3002 Registered No. 34  
 (c) City Mexico Mo (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 Maurine Pruel

(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 (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 11 - 1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
37 4 5

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) \_\_\_\_\_

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 Mar 8 1939 Blanche Keely Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 8 1939

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:

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 \_\_\_\_\_ M. D. O.  
 (Signed) H. J. Mesheim

(Address) Mexico Mo

SUPPLEMENTARY

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

