

REC'D MAY 10 1939

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

14805

Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 297
 (b) Township _____ Primary Registration District No. 3016 Registered No. 50
 (c) City Washington, Mo. (d) Street No. Mcnamara, Washington, Mo. 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 38 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Pauline Filla

(a) Residence, No. Washington, 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 OR (OR) WIFE OF Andy E. Filla.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 21, 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
59 10 7

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. Home
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 38 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Haven, Mo.13. NAME Frank Kluba14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany15. MAIDEN NAME Magdaline Chaji16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany17. INFORMANT (ADDRESS) Mr. Andy E. Filla
Washington, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Washington, Missouri DATE 5/2/3919. FUNERAL DIRECTOR (NAME) (ADDRESS) Nieburg & Vitt, Inc.,
Washington, Mo.20. FILED Apr. 29, 1939 H. A. May
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12/31, 1938, to 4/28, 1939
 I last saw her alive on April 28, 1939. Death is said to have occurred on the date stated above, at 9:15 P m.

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

Nephritis

Date of onset

Other contributory causes of importance:

Chronic Myo-carditis

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) J. J. [Signature], 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 impor

98C

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,

A. C. Nieburg, or by

Registered Apprentice No., working under my personal supervision.

Signed *A. C. Nieburg*

Licensed Embalmer No. 2387

P. O. Address Washington, Mo.

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.

PHOTODUPLICATION SERVICE

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14805
Do not use this space.

1. PLACE OF DEATH
 (a) County Franklin Registration District No. 297
 (b) Township _____ Primary Registration District No. 3016 Registered No. 50
 (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 Pauline Filla
 (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 (write the word) m

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

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

7. AGE YEARS 59 MONTHS 10 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

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 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-28 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:
Myocarditis (chronic) Date of onset _____

Other contributory causes of importance:
Chro myo Carditis

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) J. L. Post _____, M. D.
 (Address) Washington Mo.

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 EXACTLY. AGE should be stated EXACTLY. AGENT should be stated EXACTLY. PHYSICIANS should state EXACTLY.

Local Registrar.

S-14809