

REC'D JUN 21 1939

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

19083
Do not use this space.

1. PLACE OF DEATH

(a) County *Linn* Registration District No. *477*
(b) Township *Dickerson* Primary Registration District No. *5646* Registered No. *23*
(c) City *Contra* (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

(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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Widow*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 8 - 1863*
7. AGE YEARS *75* MONTHS *9* DAYS *15* If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Journal of County Home*
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 *2*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *La Grange Mo*

FATHER 13. NAME *Mike Gier*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bernsguy Mo*

MOTHER 15. MAIDEN NAME *Elizabeth Shade*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Carrie Schoedinger Contra Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Contra Mo* DATE *5-28-1939*

19. FUNERAL DIRECTOR (ADDRESS) *F. S. Kelly Contra Mo*

20. FILED *May 25 1939* *H. W. Harris M.D.* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 23* 19*39*
22. I HEREBY CERTIFY That I attended deceased from *Jan 20* 19*39*, to *May 23* 19*39*
I last saw her alive on *May 20* 19*39*. Death is said to have occurred on the date stated above, at *9 P* a. m.
The principal cause of death and related causes of importance were as follows:

Apoplexia
92 h
Date of onset *Jan 19*
Other contributory causes of importance: *High blood pressure*

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? *No*
If so, specify _____
(Signed) *Harry L. Mc Crocker D.P.H.*
Lebiston 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 important.

56

RECEIVED

District Health Officer No: 10

District File Number 10-39-1080

Date Filed 6-8-39

STATEMENT BY LICENSED EMBALMER

I, F. D. Kelly, Licensed Embalmer No. 1950

hereby certify that the body recorded on the reverse side of this certificate was embalmed by F. D. Kelly

..... L. E. No. or by Registered (Apprentice No. 1930)

working under my personal supervision.

Signed F. D. Kelly

Licensed Embalmer No.

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.)