

REC'D JUL 18 1939

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

21859  
Do not use this space.

1. PLACE OF DEATH

(a) County Black Registration District No. 190  
(b) Township 1 Primary Registration District No. L113 Registered No. 36  
(c) City Kahoka (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 Carolina Chewing

(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. M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Stephen Chewing  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 27, 1855  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
84 2 14  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At 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 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Black Per. Missouri

FATHER 13. NAME Michael Bergman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Clara Stinger

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

17. INFORMANT (ADDRESS) Mrs Rosa Kollmer  
Kahoka, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Kahoka Cem DATE June 13, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred Charles  
Kahoka, Mo.

20. FILED 6/18 1939 J. J. Bondy  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 11, 1939  
22. I HEREBY CERTIFY That I attended deceased from Jan, 1939, to June, 1939  
I last saw h. er alive on May 30, 1939 Death is said to have occurred on the date stated above, at 2:20 P.M.  
The principal cause of death and related causes of importance were as follows:

Arterio-sclerotic unknown  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: 97

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 Perry S. Boston, M. D. 0  
(Signed) Perry S. Boston  
174 (Address) Kahoka, 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.

RECORD

RECEIVED

District Health Officer No. 10

District File Number 7-39-1251

Date Filed JUL 12 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.