

AUG 11 1939

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

26548
Do not use this space.

1. PLACE OF DEATH

(a) County Pike Registration District No. 689
(b) Township ~~_____~~ Primary Registration District No. 303.3 Registered No. _____
(c) City LOUISIANA (d) Street No. 1105 Maryland 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. 0 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1105 Maryland 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 OF (OR) WIFE OF HR. Penick
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 27-1882
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 56 11 19
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. _____
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) St. Louis Mo

13. NAME Chris Fickback

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

15. MAIDEN NAME Elizabeth Bollman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

17. INFORMANT (ADDRESS) HR. PENICK - LOUISIANA Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE River View DATE July 31, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) St. Mary's Mo

20. FILED July 30, 1939 J. H. Kelly Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 29, 1939

I HEREBY CERTIFY That I attended deceased from May 9, 1939 to July 29, 1939.
I last saw her alive on July 29, 1939. Death is said to have occurred on the date stated above, at 1815 E _____.

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

Malignant abdomen Date of onset _____

Other contributory causes of importance: _____

Name of operation intestinal resection Date of _____
What test confirmed diagnosis? _____ as 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) St. Miller M. D.
(Address) Louisiana Mo

58

RECEIVED

District Health Officer No. 10

District File Number 8-39-1337

Date Filed AUG 4 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, _____

Norval Turner, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Norval Turner

Licensed Embalmer No. 3720

P. O. Address Louisiana

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26548
Do not use this space.

1. PLACE OF DEATH

(a) County Peru Registration District No. 689
(b) Township _____ Primary Registration District No. 3033 Registered No. _____
(c) City Louisiana (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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

Adeline Elizabeth Perieck
(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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 11 19

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) (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__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-29, 1937

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:

Maternal abdomen
Abdominal Region
46
Date of onset _____
Other contributory causes of importance: _____

Name of operation Intestinal Resection 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) H. Miller, M. D.
Louisiana (Address) mo

SUPPLEMENT

S-26548

1938