

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 773

Primary Registration District No. 60184

1. PLACE OF DEATH: 3  
 (a) County St. Francois County  
 (b) City or town Farmington  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital No. 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME Marie Elizabeth Lenze 520  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 9 4 1911  
 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
27	10	26	hr. _____ min.

9. Birthplace New Haven Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business 0

MOTHER FATHER { 12. Name Frank Lenze

13. Birthplace Germany  
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Anna Laven

15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Records of State Hosp. #4  
 (b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 8-1-1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Haven, Mo.

18. (a) Signature of funeral director Earl C. Tertig  
 (b) Address New Haven, Mo.

19. (a) Aug-8-39 (b) B. J. Robinson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1  
 (a) State Missouri (b) County Franklin  
 (c) City or town New Haven, Route 3, Box 24  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 30  
 year 1939 hour 10:52 p.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 7-26, 1939 to 7-30, 1939;  
 that I last saw her alive on 7-30  
 and that death occurred on the date and hour stated above.

Immediate cause of death Epidemic Paratyphoid / Duration 4 or 5 days

Due to Left Lobar Pneumonia, Massive 2 days

Other conditions Paralysis with Epilepsy 23 years?  
 (Include pregnancy within 3 months of death)

Major findings: Of operations None - no operation PHYSICIAN \_\_\_\_\_  
 Of autopsy None - No autopsy Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature C. C. Ault (M. D. certifier)  
 Address Farmington, Mo. Date signed \_\_\_\_\_

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San Francisco County

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Carl C. Vestig

Licensed Embalmer No. 3385

P. O. Address New Haven

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

301067  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773  
 (b) Township St. James Primary Registration District No. 6018A  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. 130  
 (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

Marie Elizabeth Lenge  
 (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 S  
 (Write the word)

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

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

7. AGE YEARS 27 MONTHS 10 DAYS 26  
 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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 30 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:

Epileptic Paralysis (Mumps)  
Left Lobar Pneumonia  
Psychosis with epilepsy  
 Date of onset \_\_\_\_\_

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? \_\_\_\_\_

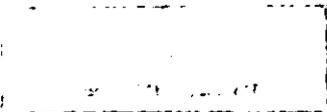
If so, specify \_\_\_\_\_ (Signed) C. C. Ault, M. D.  
 (Address) Garmanville, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES

THEY ARE COMPLETED AS PRESCRIBED BY LAW.

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
DIVISION OF ENTOMOLOGY



TO THE DIRECTOR, BUREAU OF PUBLIC HEALTH  
WASHINGTON, D. C.

FROM: [Name/Title]

SUBJECT: [Subject]



RECEIVED [Date]

OFFICE OF THE DIRECTOR  
BUREAU OF PUBLIC HEALTH  
WASHINGTON, D. C.

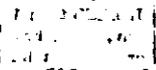
MEMORANDUM FOR THE DIRECTOR

DATE: [Date]

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SUBJECT: [Subject]



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