DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D SEP 15 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30305

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 132

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall, Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbons Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution nine Days (Specify whether In this community years, months or days) yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Marshall, Mo (If outside city or town limits, write "RURAL")

(d) Street No. 803 N. Hammer (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME AGNES LEE KRUMSIEK

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 married

6. (b) Name of husband or wife EDWIN LEE KRUMSIEK (c) Age of husband or wife if alive 44 years

7. Birth date of deceased JAN. (Month) 7 (Day) 1897 (Year)

8. AGE: Years	Months	Days	If less than one day
42	6	26	— hr. — min.

9. Birthplace MIAMI (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation Housewife

11. Industry or business —

FATHER
12. Name Robert M. Huyett
13. Birthplace SHEPHERDSTOWN, WEST. VIR. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MOLLIE KILE
15. Birthplace MIAMI (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant's own signature Virginia Huyett Furry

(b) Address Carrollton, Mo

17. (a) Ridge Pr. Cemetery (Burial, cremation, or removal) (b) Date thereof Aug 5, 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Mo

18. (a) Signature of funeral director J. L. Sweeney

(b) Address 417 So. Odell, Marshall, Mo

19. (a) 8-3-39 (Date received local registrar) (b) Mary Kent Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3 year 39 hour 11 minute 40 A M.

21. I hereby certify that I attended the deceased from July 25, 1939, to Aug 3, 1939; that I last saw her alive on Aug 3, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Peritonitis (ulcer)	7/28/39
Due to Ruptured ulcer of Jugenum	?
Due to	
Other conditions (Include pregnancy within 3 months of death) Post operative July 25 - 39	

PHYSICIAN

Major findings: Of operations Petro Version uterus

Of autopsy Ruptured ulcer Free fluid in abd Cavity

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) no

(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? (Specify type of place)

While at work? (e) Means of injury

26. Signature [signature] (M. D. or other)

Address Marshall Mo Date signed 8/3/39

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1202

RECEIVED
District Health Officer No. 8,
File Number 9/11/39
Filed

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 myself, Registered Apprentice No. —

working under my personal supervision.

Signed J. Leslie Sussing

Licensed Embalmer No. 3235

P. O. Address Marshall, Mo.

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

30305

Do not use this space.

1. PLACE OF DEATH

(a) County: Saline — Registration District No. 796

(b) Township: Marshall — Primary Registration District No. 3038 — Registered No. 132

(c) City: ..... (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: Agnes Lee Krumsiek

(a) Residence, No. ..... St.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 42 — Months 6 — 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) 8-3 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:

	Date of onset
Perforating (ulcer)	
Ruptured ulcer of	
Jejunum	
Post operative 7/25/39	

Other contributory causes of importance:

Retroversion uterus

Ruptured ulcer

There was no pregnancy

Name of operation ..... Date of op. .....

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) S. P. Simpson, M. D.

(Address) Marshall Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. ... REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE OF DEATH UNTIL ... ARE COMPLETED AS PRESCRIBED BY LAW.

S-30305