

OCT 13 1939

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

32920
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533
 (b) Township Hudson Primary Registration District No. 5713 Registered No. 78
 (c) City St. Louis (d) Street No. 5111 North Lantana
 (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

Irma Madeline Lietz
 (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 Caucasian 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. H. G. Lietz
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15 - 1908
 7. AGE YEARS MONTHS DYS If LESS than 1 day, _____ hrs. or _____ min.
31 1 20
 OCCUPATION 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) Cottor Arkansas

FATHER 13. NAME Harvey N. Force
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Maudie Wood
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gainesville Mo

17. INFORMANT Dr. H. G. Lietz
 (ADDRESS) Seymour Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Humboldt Mo DATE 9/6 1939

19. FUNERAL DIRECTOR (ADDRESS) W. A. Mason Mo

20. FILED 9/8 1939 Seymour Mo Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 4 1939

22. I HEREBY CERTIFY, that I attended deceased from July 8 1939 to Sept 4 1939
 I last saw her alive on Sept 4 1939. Death is said to have occurred on the date stated above, at 9:55 a.m.
 The principal cause of death and related causes of importance were as follows:

Peritonitis Date of onset Sept 2 1939

Other contributory causes of importance: Exhaustion psychosis following pneumonia Feb 1939 July 1 1939

Name of operation none Date of _____
 What test confirmed diagnosis? clinical Was 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) H. Doyle G.O. M.D.
 (Address) Macon 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.

I X1204

124

RECEIVED

District Health Officer No. 10

District File Number 10-39-1731

Date Filed OCT 5 1939

STATEMENT BY LICENSED EMBALMER

I, George H. Nile, Licensed Embalmer No. 4066

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. _____ or by _____ Registered Apprentice No. _____
working under my personal supervision.

Signed George H. Nile
Licensed Embalmer No. 4066

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.)

RECEIVED
CITY OF
MILWAUKEE

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32920
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533
 (b) Township Anderson Primary Registration District No. 8713 Registered No. _____
 (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

(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 7 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.
31 1 20

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) Sept 4 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him _____ 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:

peritonitis
108
 Other contributory causes of importance:
transfusion psychosis
following pneumonia
abuse

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) H. P. Hoyle, M. D.

(Address) Macon Mo

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

