

FILED JAN 23 1941

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

42071

Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 131
 (b) Township Randolph Primary Registration District No. 5782
 (c) City None (d) Street No. Route I 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.

Registered No. _____

2. PRINT FULL NAME

(a) Residence, No. Adolph Nabe 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 28th 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 8 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
 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) Cape Girardeau County13. NAME Unknown14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "15. MAIDEN NAME "16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "17. INFORMANT Mrs Rosa Foeste
(ADDRESS) Cape Girardeau Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Hobbs Chapel DATE Dec 29th, 194019. FUNERAL DIRECTOR (NAME) Brankopf Howell
(ADDRESS) Cape Girardeau Mo20. FILED Jan 10, 1941 Olewig J Miller Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 26th 194022. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1940, to Dec 26, 1940I last saw her alive on Dec 25, 1940 Death is said to have occurred on the date stated above, at 10:50 p.m.

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

Bright's disease Date of onset _____Other contributory causes of importance: Paralysis of a part of muscles of suicide
Child of genius

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 _____

(Signed) J Miller M. D.Address Cape Girardeau12427-40

182

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42071

Registration District No. 131

Primary Registration District No. 5182

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Randolph T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Adolph Nabe
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m 5. Color or race W
6. (a) Single, widowed, married, divorced Div
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 28
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 9 (b) Oliver J. Miller
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir
(c) City or town Rural
(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 Dec day 26
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bright's disease acute

Due to _____
Due to _____ 130

Other conditions Paralysis of part
(Include pregnancy within 3 months of death)

Major findings: fracture of the middle
Of operations: third of femur
Of autopsy: Wier hospital for
date not designated
Kremer

PHYSICIAN
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 O. J. Miller (M. D. or other) _____

Address Cape Gir Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1990

S-42071