LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED NOV 6 1941

State File No. 35929

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH

(a) County St Charles

(b) City or town Rural

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

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED

(a) State Mo (b) County St Charles

(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.

3. (a) PRINT FULL NAME CLARA FIENUP

3. (b) If veteran, name war .....

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased April (Month) 17 (Day) 1867 (Year)

8. AGE: Years 84 Months 6 Days 27 If less than one day ..... hr. ..... min.

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

10. Usual occupation House wife

11. Industry or business .....

FATHER
12. Name Martin Giessman
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dant Knan
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marie Weber

(b) Address St Louis

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 14th year 1941 hour X minute ..... M.

21. I hereby certify that I attended the deceased from Oct 7th 1941 to Oct 14th 1941; that I last saw her alive on Oct 13th 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (apoplexy) — Duration 7 days

Due to Arterio Sclerosis & old age

Due to 430

Other conditions Varicose veins, Varicose ulcers (Include pregnancy within 3 months of death) Senile dementia

Major findings: Of operations No operation

Of autopsy No autopsy

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) No accident

19. (a) (Date received local registrar) (b) (Registrar's signature)

(b) Address

23. Signature (M. D. or other) Address Date signed

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

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State File No......

Registration District No..... Primary Registration District No..... *Registrar's No.*.....

1. PLACE OF DEATH

(*a*) County.....

(*b*) City or town.....
(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 years, months or days)
In this community.....

2. USUAL RESIDENCE OF DECEASED

(*a*) State..... (*b*) County.....

(*c*) City or town.....
(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.

3. (*a*) PRINT FULL NAME.....

3. (*b*) If veteran, name war..... 3. (*c*) Social Security No.....

4. Sex..... 5. Color or race..... 6. (*a*) Single, widowed, married, divorced.....

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	Months	Days	If less than one day
			.....hr. .....min.

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

10. Usual occupation.....

11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)

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

16. (*a*) Informant's own signature.....

(*b*) Address.....

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

(*c*) Place: burial or cremation.....

18. (*a*) Signature of funeral director.....

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month.....day.....
year.....hour.....minute.....M.

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

	Duration
Immediate cause of death.....	
Due to.....	
Due to.....	
Other conditions..... (Include pregnancy within 3 months of death)	
Major findings: Of operations.....	
Of autopsy.....	

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?
.....
(Specify type of place)

While at work?..... (*e*) Means of injury.....

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.