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

PLACE OF DEATH

County Pettis

Township Sedalia or Village ..... or City ..... (NO. ..... St.: ..... Ward)

Registration District No. 668 Primary Registration District No. ~~3089~~ 5880

File No. 15913 Registered No. 135

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Laura Henrietta Eicholz

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH: June 19, 1866 (Month) (Day) (Year)

AGE: 50 yrs. 10 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

BIRTHPLACE (City or town, State or foreign country): Dont know

PARENTS

NAME OF FATHER: Jimmerscheidt

BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know

MAIDEN NAME OF MOTHER: " "

BIRTHPLACE OF MOTHER (City or town, State or foreign country): " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A F Neumeyer

(ADDRESS) Smithton Mo.

Filed May 4, 1917. W B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr. (Month) 14 (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1917, to Apr 14, 1917, that I last saw h er alive on Apr 3, 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

(Duration) ..... yrs. 6 mos. — ds.

Contributory (SECONDARY) Nothing

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed Albers M. D.

Apr 16, 1917 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasant Hill Cem.	April 16 1917
UNDERTAKER	**ADDRESS**
A F. Neumeyer	Smithton

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN R... ...DING

V. S. No. 2.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, stat (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, O RECENT RESIDENTS)

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... d

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191...
UNDERTAKER	ADDRESS