

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

Do not use this space.

35687

DEC 18 1935

1. PLACE OF DEATH

County FRANKLIN Registration District No. 292
Township BOEHF Primary Registration District No. 3-410
City L (No. _____) St. _____ Ward _____

2. FULL NAME

ANNIE SOPHIA OBERWURTMANN

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? 72 yrs. 6 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF LOUIS OBERWURTMANN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APR. 30 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 6 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. HOUSEWIFE

9. Industry or business in which work was done, as silk mill, 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) BERGER MO

13. NAME CHARLES HELMENDICZ

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) LITTLE BERGER MO

15. MAIDEN NAME CAROLINE LANGEN DUEFFEL

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) HERMANN MO

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Home DATE Nov-17 35

19. UNDERTAKER (ADDRESS) J. F. Oberwurtmann

20. FILED Nov 16 1935 Jeffie Grammer Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) NOV-14 1935

22. I HEREBY CERTIFY, That I attended deceased from OCT 25 35 to Nov 14 35

I last saw her alive on OCT 25 35 Death is said to have occurred on the date stated above, at 8:15 A.M. in _____

The principal cause of death and related causes of importance were as follows: _____ Date of onset _____

Cerebral Apoplexy

Other contributory causes of importance _____

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) W. E. Embick M. D. (Address) New Haven, Mo.

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

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.

