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.

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

33018

PLACE OF DEATH

County Cape Girardeau

Township ——— Registration District No. 125 File No.

or Village ——— Primary Registration District No. 3009 Registered No. 1278

or City Cape Girardeau (NO. St. Francis Hospital St.: ——— Ward)

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

FULL NAME Appolonia Bauman

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: Jan (Month) 5 (Day), 1834 (Year)

AGE: 81 yrs. 10 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Germany

PARENTS
NAME OF FATHER: Christian Roessler
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Theo Bauerle

(ADDRESS) Cape Girardeau Mo

Filed Nov 17, 1915 R. W. Frissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 15 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 22, 1915, to Oct 23, 1915, that I last saw her alive on Oct 23, 1915, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

OLA

64

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

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. 24 ds.

(Signed) T. R. Williams M. D.

Nov 17, 1915 (Address) Cape Girardeau 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: Old Catholic Cem

DATE OF BURIAL: Nov 17, 1915

UNDERTAKER: Al Brinkopf

ADDRESS: Cape Girardeau 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.

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

..... (Month) ..... (Day), *1*..... (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

..... (Month) ..... (Day), *191*..... (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, 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 ..... 191....
UNDERTAKER	ADDRESS