

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

Do not use this space.

1. PLACE OF DEATH

County Lincoln Registration District No. 972 File No. 5343
 Township _____ Primary Registration District No. 2652-B Registered No. 3
 City Mason Mills (No. _____) St. _____ Ward _____

2. FULL NAME

(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

Female White

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 25 - 1927

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, _____ hrs. or _____ min. |
|--------|-------|-----------|-----------|--|
| | | <u>10</u> | <u>22</u> | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mason Mills
 (STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER August Rahmmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lincoln Mo
 (STATE OR COUNTRY) _____

12. MAIDEN-NAME OF MOTHER Helma Osthoff

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lincoln Mo
 (STATE OR COUNTRY) _____

14. INFORMANT August Rahmmer
 (Address) Mason Mills Mo

15. FILED _____, 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19 1928

17. I HEREBY CERTIFY, That I attended deceased from _____
Feb 11, 1928, to Feb 19, 1928
 that I last saw h. m. alive on Feb 15, 1928, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
107 D
106 D 100 D
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY base
 (SECONDARY) _____
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

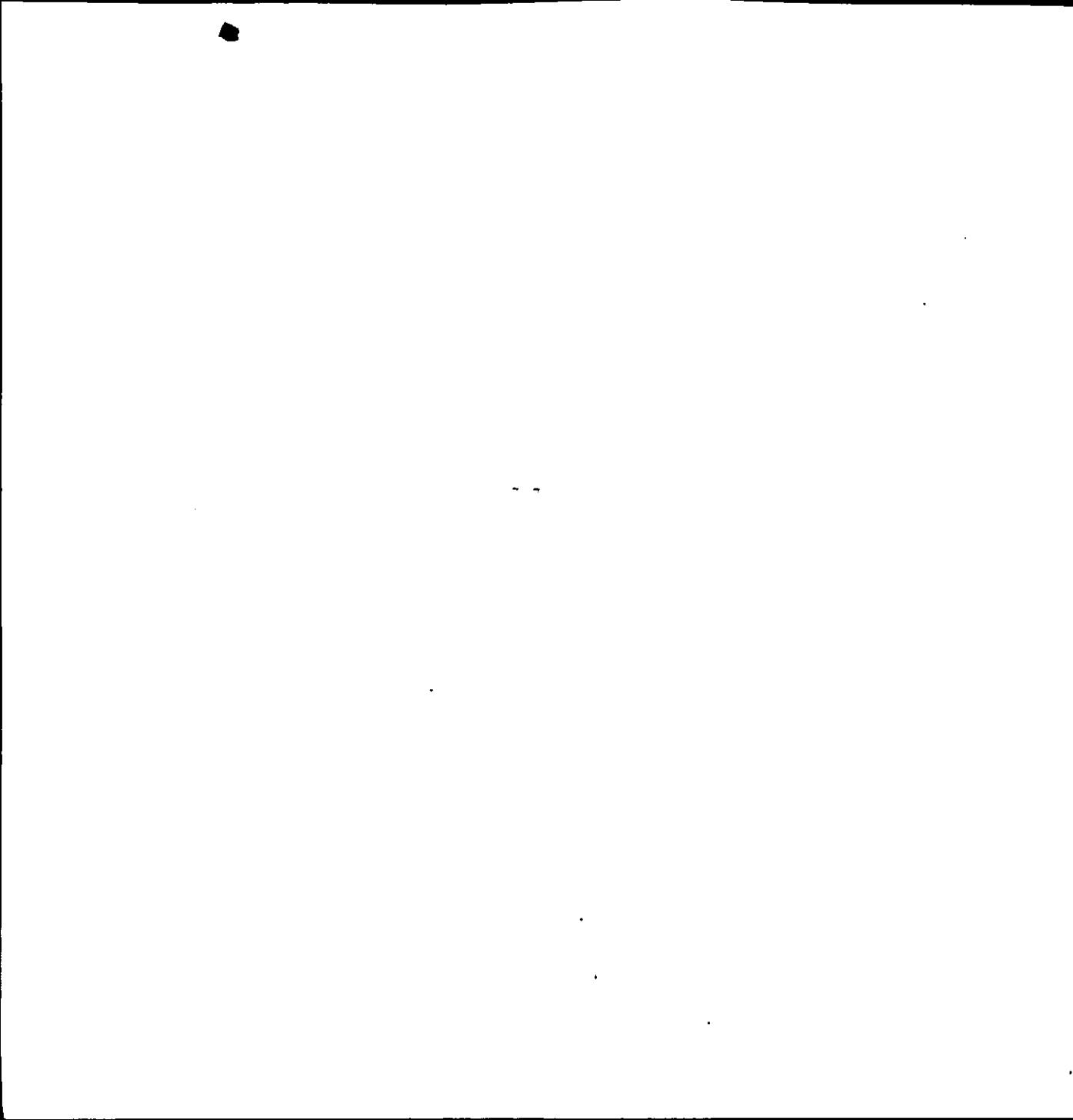
(Signed) H. A. Stephens, M. D.

Feb 20, 1928 (Address) Mason Mills Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Other Country DATE OF BURIAL Feb 20 1928

20. UNDERTAKER Kemp Bros ADDRESS Troy Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lincoln Registration District No. 972 File No. _____
 Township _____ Primary Registration District No. 5652B Registered No. _____
 City Moscow Mills St. _____ Ward _____

2. FULL NAME

Rosette Rahmier

(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED — (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 28-1927

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. Let 22, 1927 H. A. Shepherd M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-19 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, _____, 19____.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

