(Hill)

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

Do not use this space.

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1. PLACE OF DEATH

County: Cole — Registration District No.: 217 — File No.:

Township: — Primary Registration District No.: 0014 — Registered No.: 11

City: Jefferson (No. , St. Ward)

2. FULL NAME: Mrs Emma Catherine Elizabeth Rockemann

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

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: 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: Mathias Rockemann

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 14 1900

7. AGE: Years 29 — Months 6 — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer): " "
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lohman, Mo.

PARENTS

10. NAME OF FATHER: Fred Koestner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Lohman Mo.

12. MAIDEN NAME OF MOTHER: Anna E. Strobel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Lohman, Mo.

14. INFORMANT: Mathias Rockemann
(Address): Zion, Mo.

15. FILED 1-7, 1929 S. V. Bedford, REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 3, 1929, that I last saw her alive on Jan 3, 1929, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
149B
108
112 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY): Childbirth + Asthma (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home

DID AN OPERATION PRECEDE DEATH? no. DATE OF —

WAS THERE AN AUTOPSY? no —

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Jas A. Hill M. D.

1-7, 1929 (Address) Jefferson City 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: Zion Cemetery — DATE OF BURIAL: 1-8 1929

20. UNDERTAKER: Wymore-Gordon — ADDRESS: Jeff City Mo.

N. B.—Every ... should be stated ... CAUSE OF DEATH ... classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Cole. Registration District No.: 213. File No.:

Township: Primary Registration District No.: 3014 Registered No.: 11

City: Jefferson (No. ; St. Ward)

2. FULL NAME: Emma Catherine Elizabeth Rockemann

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

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): M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 14 1900.

7. AGE: Years 28 | Months 5 | Days 21 | If LESS than 1 day, hrs. or min.

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)
(STATE OR COUNTRY)

PARENTS

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. FILED 1-7 1929 Sue Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 5 1929 19

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, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in detail, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

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

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