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

File No. 36601

Registration District No. 422

Primary Registration District No. 1577

Registered No.

1 PLACE OF DEATH

County: Jeff.

Township: Central

or Village: Hillsboro Mo

or City: (NO. St.: Ward)

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

2 FULL NAME Alice Ehlers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word)

6 DATE OF BIRTH: May 27, 1913 (Month) (Day) (Year)

7 AGE: 17 yrs. 5 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Hillsboro Mo

PARENTS

10 NAME OF FATHER: Oscar Ehlers

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Home Springs Mo.

12 MAIDEN NAME OF MOTHER: Pauline Kassel

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Antonia Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Ehlers
(Address) Hillsboro Mo

15 Filed Nov 17, 1930 Wm Evans Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 14th (Month) (Day), 1930 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 14, 1930, to ....., 191....,
that I last saw h. alive on Nov 14, 1930,
and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of R Lungs

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

CONTRIBUTORY (Secondary)

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

(Signed) G M, MD Kirkwood 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.

18 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

19 PLACE OF BURIAL OR REMOVAL: St Paul's Lutheran Cemetery

DATE OF BURIAL: Nov 17, 1930

20 UNDERTAKER: Fred A Heilig

ADDRESS: RR #3 Kimmswick Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. 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 OI
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If d
hospita
give it
of stre

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day

17 I HEREBY CERTIFY, that I attended
....., 191....., to .....
that I last saw h..... alive on .....
and that death occurred, on the date stated above,
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. .....

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. .....

(Signed) .....

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

*State the Disease Causing Death, or, in deaths from Viol
(1) Means of Injury; and (2) whether Accidental, Suicide

18 LENGTH OF RESIDENCE (For Hospitals, Institutio
or Recent Residents)

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF B

20 UNDERTAKER	ADDRESS