

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

Do not use this space.

27971

1. PLACE OF DEATH

County Franklin Registration District No. 297
 Township Washington Primary Registration District No. 3016
 City Washington (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 97

2. FULL NAME Leona Brueggenjohann

(a) Residence, No. Hancock Street St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 6 mos. 0 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
~~Widow~~
 (OR) WIFE OF Walter Brueggenjohann

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 26, 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>37</u>	<u>2</u>	<u>16</u>	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>
	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) Higginsville
 (STATE OR COUNTRY) Missouri

13. NAME Hy. F. Ridder

14. BIRTHPLACE (CITY OR TOWN) Warren County
 (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Mathilda Hackmann

16. BIRTHPLACE (CITY OR TOWN) Warren County
 (STATE OR COUNTRY) Missouri

17. INFORMANT Walter Brueggenjohann
 (ADDRESS) Hancock St., Washington, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE St. Peters Cemetery DATE Aug. 16, 1931

19. UNDERTAKER Otto & Co.,
 (ADDRESS) Washington, Mo.

20. FILED Aug 14 1931 O. L. Munch
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 12, 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1931 to Aug 12, 1931

I last saw her alive on Aug 12, 1931. Death is said to have occurred on the date stated above, at 4:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis
Dilatation
Surgical Operations
 Date of onset _____

Other contributory causes of importance:
Surgical Operations

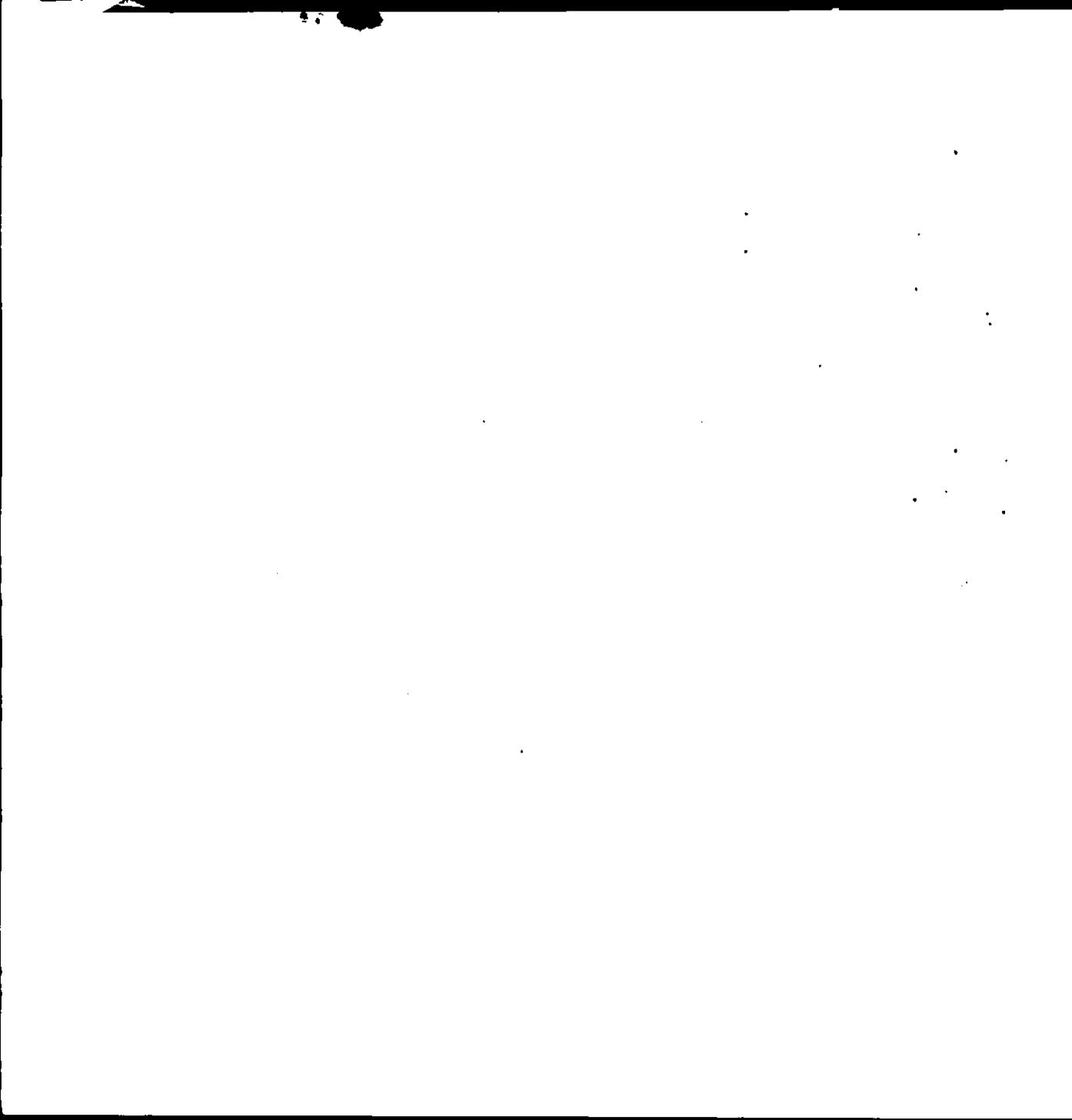
Name of operation Gastro-entriostomy Date of Aug 12, 1931
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? No
 If so, specify _____

(Signed) Joseph W. Mays M. D.
 (Address) Washington, Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Franklin Registration District No. 297 File No.
 Township Primary Registration District No. 3016 Registered No. 91
 City Washington (No.) St. (Ward)

2. FULL NAME

Leona Brueggemann
 (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) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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
 (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)

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)

FILED Aug 14 31 O. L. Muench REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac dilatation
gastroenterostomy performed for bleeding gastric ulcer, ds.

CONTRIBUTORY (SECONDARY) Surgical Operation

18. WHERE WAS DISEASE CONTRACTED 117 W

IF NOT AT PLACE OF DEATH.....
gastroenterostomy Aug 5 / 31
 DID AN OPERATION PRECEDE DEATH? yes DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Frank H. Mays M. D.
 , 19 (Address) 509 W 4th Washington 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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

PARENTS

1467C-5