

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

Do not use this space.

7127
File No. _____
Registered No. _____

1. PLACE OF DEATH

107 County Texas
Township Carroll
City _____ (No. _____) St. _____ Ward _____

Registration District No. 8069A
Primary Registration District No. 6120

2. FULL NAME

Feb Lena Weise
(a) Residence. No. Summersville 148 Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2 16 32

7. AGE YEARS MONTHS DAYS .If LESS than 1 day, hrs. or min.
81 0 30

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Germany 10. (STATE OR COUNTRY) _____

10. NAME OF FATHER Ewaldt

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

12. MAIDEN NAME OF MOTHER Dora Knauer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany 11. (STATE OR COUNTRY) _____

14. INFORMANT Carl Kuehl
(Address) Summersville

15. FILED Feb. 19 32 52 2 N Waller
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 / 16 19 32

17. I HEREBY CERTIFY, That I attended deceased from 2/15 1932, to 2/16 1932 that I last saw him alive on 2/15 1932 and that death occurred, on the date stated above, at 9:20 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Arteriosclerotic Nephritis

131
92 A (duration) yrs. mos. ds.
CONTRIBUTORY Seepage of heart
(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) J. M. Reed M. D.
. 19 (Address) Summersville 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 Manilla Iowa DATE OF BURIAL Feb 18 1932

20. UNDERTAKER Duncan Mt View ADDRESS _____

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.

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

APR 25 1932

