

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

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.

AUG 14 1934

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

Do not use this space.

1. PLACE OF DEATH

County Cape Girardeau
Township Apple Creek
City Oak Ridge mo (No. St. Ward)

Registration District No. 128
Primary Registration District No. 5176B

File No. 23589
Registered No.

2. FULL NAME Pullie Row

(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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Peopse Row</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 1889</u>		
7. AGE YEARS <u>47</u>	MONTHS <u>8</u>	DAYS If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>		11. Total time (years) spent in this occupation
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)		

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Hy Wolfenkoehler
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Not known
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Rayne Row
(ADDRESS) Oak Ridge mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bohannon DATE July 17 1934

19. UNDERTAKER McGrath F & Co
(ADDRESS) Jackson mo

20. FILED 101934 19 34
Laura Siebe
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16th 1934
22. I HEREBY CERTIFY, That I attended deceased from July 14th 1934 to July 16th 1934
I last saw her alive on July 16th 1934. Death is said to have occurred on the date stated above, at 2 A. m.
The principal cause of death and related causes of importance were as follows:

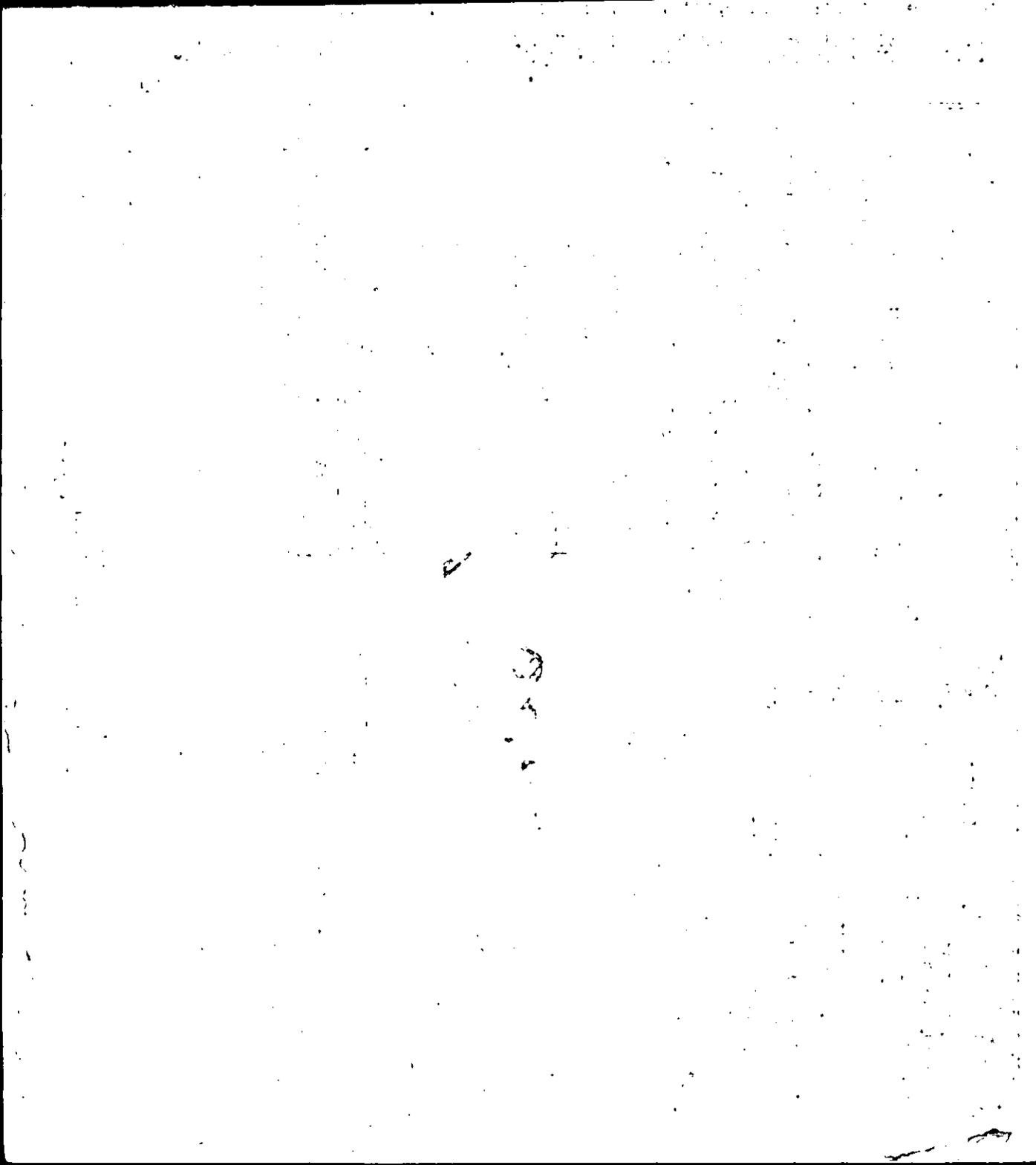
Suicidal
163 F

Other contributory causes of importance: _____
Name of operation _____ Date of _____
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? _____
If so, specify _____
(Signed) A. J. Masten M. D.
(Address) Oak Ridge Mo.



#2 Cape Girardeau

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McLaughlin, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Tillie Dow
Who died at _____ on July - 16 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 47 Months 8 Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Suicidal Concentrated Eye used, no cause known.

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following: None

Accident, suicide, or homicide? Suicide Date of injury None, 19 _____

Where did injury occur? Cape Girardeau Co. Mo.
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Home

Manner of injury Toxicity of Concentrated Eye

Nature of injury Behind of throat & mouth?

Was disease or injury in any way related to occupation of deceased? NO

If so, specify _____

Name of physician A. J. Martine

Address of physician _____

Signature of Registrar Laura (Deach) Hebe Date filed Aug-10-1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 128

Primary Reg. Dist. No. 517683

Very truly yours,
E. T. McLaughlin, M.D.
Special Agent.

S-23589