

730 OCT 24 1938

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

32937

Do not use this space.

PLACE OF DEATH

(a) County Orange Registration District No. 644
 (b) Township Spring Primary Registration District No. 5853 Registered No. 13
 (c) City Rock Creek (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Rock Creek, MO St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Christine Vossen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 8, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
73 5 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as 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) (STATE OR COUNTRY) Orange Co, MO

FATHER 13. NAME Adolph Vossen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Louise Reutter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Mrs. Louise Vossen
Rock Creek, MO

18. BURIAL, CREMATION, OR REMOVAL PLACE Rock Creek, MO DATE Oct 9, 1938

19. FUNERAL DIRECTOR (ADDRESS) Morton Funeral Home
Lincoln, MO 575

20. FILED 10-8-38 Emily Maltz Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 5, 1938

22. I HEREBY CERTIFY, That I attended deceased from 1-1-37 to October, 1938

I last saw him alive on September 28, 1938 Death is said to have occurred on the date stated above, at 5 p.m.

The principal cause of death and related causes of importance were as follows:

Uremia

Date of onset 10-1-38

Other contributory causes of importance:

Endocarditis
Myocarditis
Nephritis

Name of operation Clinical Date of 10
 What test confirmed diagnosis? Clinical Was there an autopsy? No

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

Proo, specify (Signed) H. C. Smith, M.D. M. D.
 (Address) Lincoln, MO

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

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STATEMENT BY LICENSED EMBALMER

A. C. Birmingham

Licensed Embalmer No. *3664*

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

me

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed *A. C. Birmingham*

Licensed Embalmer No. *3664*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32937
Do not use this space.

1. PLACE OF DEATH

(a) County Oregon Registration District No. 644
 (b) Township Linn Primary Registration District No. 3853
 (c) City Linn (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. My, Albert Vossen St. (if nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE YEARS <u>73</u>	MONTHS <u>5</u>	DAYS <u>8</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as 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) (STATE OR COUNTRY)		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE		
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED _____, 19____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 5 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

Infarctus cordis
myocarditis
nephritis

Other contributory causes of importance:
Chronic
Chronic
Chronic

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) H. C. Hummel, M. D.
 (Address) Linn, Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

