

REC'D JUN 8 1939

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

18561
Do not use this space.

1. PLACE OF DEATH
(a) County Franklin Registration District No. 297
(b) Township Washington Primary Registration District No. 3016 Registered No. 53
(c) City Washington (d) Street No. E. Fifth St. 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 75 yrs. X mos. X da. (f) How long in U.S., if of foreign birth 74 yrs. mos. da.

2. PRINT FULL NAME Josephine Bleinich
(a) Residence, No. E. Fifth St. Washington, Mo. St. (If nonresident, give city or town and State)

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 HUSBAND OF (OR) WIFE OF Robert Bleinich

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 26th, 1839.

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|------------|----------|-----------|--|
| | <u>100</u> | <u>3</u> | <u>19</u> | |

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife.

9. Industry or business in which work was done, as saw mill, bank, etc. X

10. Date deceased last worked at this occupation (month and year) May 1939. 11. Total time (years) spent in this occupation X

12. BIRTHPLACE (CITY OR TOWN) Unknown. 6
(STATE OR COUNTRY) Germany.

FATHER

13. NAME Unknown. 9
14. BIRTHPLACE (CITY OR TOWN) Unknown. 9
(STATE OR COUNTRY) Unknown.

MOTHER

15. MAIDEN NAME Unknown.
16. BIRTHPLACE (CITY OR TOWN) Unknown.
(STATE OR COUNTRY) Unknown.

17. INFORMANT Mr. Charles Bleinich.
(ADDRESS) Washington, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington, Mo. DATE May 17th, 1939.

19. FUNERAL DIRECTOR (NAME) Nieburg & Vitt, Inc.
(ADDRESS) Washington, Mo.

20. FILED May 15-1939 H.A. May
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15th, 1939.

22. I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1839, to May 15, 1939
I last saw her alive on Mar. 18, 1939. Death is said to have occurred on the date stated above, at 1:00 A.M.
The principal cause of death and related causes of importance were as follows:
Heart Failure ✓ Date of onset 3-18-39

Other contributory causes of importance:
Arteriosclerosis 3-18-39

Name of operation _____ Date of _____
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.
If so, specify _____
(Signed) [Signature] _____, M. D.
Washington, Mo.

270 (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.

97

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

Lester A. Witt

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Lester A. Witt

Licensed Embalmer No. *3254*

P. O. Address *Washington, Md.*

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
 (a) County Franklin Registration District No. 297
 (b) Township Washington Primary Registration District No. 3016 Registered No. 53
 (c) City Washington (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 Josephine Bleinich
 (a) Residence, No. _____ 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 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. |
| | <u>100</u> | <u>3</u> | <u>19</u> | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

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) _____

FATHER

13. NAME _____

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

MOTHER

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-15-1939

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

I last saw h. _____ 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:

Heart failure
Chronic myocarditis 1-20-37

Arterio sclerosis 1-20-37

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? clinical 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) R. E. Markgraf, M. D.
 (Address) Washington

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED 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.

Local Registrar.

