

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

Do not use this space.

1. PLACE OF DEATH

County Barry Registration District No. 30 File No. 7723
 Townshp. Cappolcreek Primary Registration District No. 5041 Registered No. 16
 City (No. St. Ward)

2. FULL NAME Nabriel Meister

(a) Residence, No. St. Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anton Meister
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 20 - 1847
 7. AGE YEARS 87 MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 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) Perry Co. Missouri
 (STATE OR COUNTRY)

FATHER 13. NAME Michael Hopper

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

MOTHER 15. MAIDEN NAME Mat Kuson

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

17. INFORMANT Walter Meister
 (ADDRESS) Monett, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Stones Prairie DATE 3-22-1934

19. UNDERTAKER Blaine Parkin
 (ADDRESS) Purdy Mo.

20. FILED 3-26-34 W. M. West
 Registrar.

MEDICAL CERTIFICATE OF DEATH

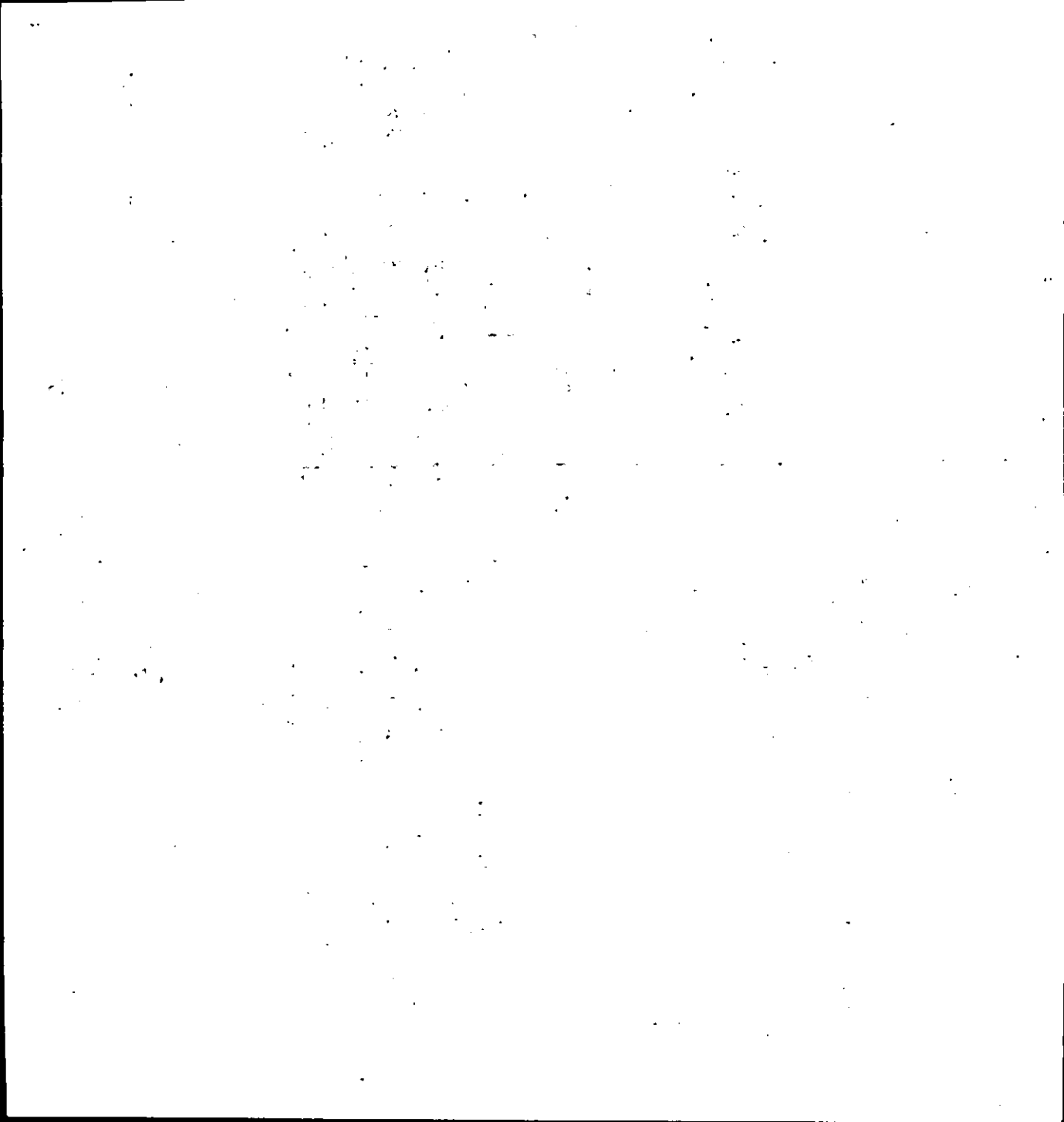
21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 20, 1934
 22. I HEREBY CERTIFY, That I attended deceased from Feb 15th, 1934, to March 18th, 1934
 I last saw him alive on Mar 18th, 1934. Death is said to have occurred on the date stated above, at 4:35 p.m.
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis approx. 7-8 yrs. onset 1920
13
 Other contributory causes of importance:
My peritonitis
Chronic Glomerulonephritis

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
 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) J. D. Baldwin, M.D.
 (Address) Purdy Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Barry Registration District No. 30
Township Capps Creek Primary Registration District No. 5041
City (No. _____) St. _____ Ward _____

File No. _____
Registered No. 16

2. FULL NAME

Gabriele Mueller
(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 W (write the word)

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.
87 4 20

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

19. UNDERTAKER (ADDRESS)

20. FILED _____ 19 _____ W. M. West Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 20, 1934

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

_____ Date of onset _____
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) _____, M. D. (Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-772B