

APR 27 1936

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

Do not use this space.

18161

1. PLACE OF DEATH

County SchuylerRegistration District No. 806Township PrariePrimary Registration District No. 6071City Queencity Mo.

(No. _____)

St. _____ Ward _____

2. FULL NAME Minnie Yearsn

(a) Residence, No. _____

(Usual place of abode)

St. _____

Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 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)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OFBill Yearsn6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 23 1867

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.69110

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.House Work9. 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 life12. BIRTHPLACE (CITY OR TOWN) Near Queencity

(STATE OR COUNTRY)

Mo.13. NAME Christopher Weitzel

14. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany15. MAIDEN NAME Minnie Wellhemine,

16. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany17. INFORMANT Bill Yearsn

(ADDRESS)

Queencity Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Germania Cemetary

DATE

April 5 193619. UNDERTAKER Wm N. Host

(ADDRESS)

Queencity Mo.20. FILED 4/4 1936J. F. Jones

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 3 1936

22. I HEREBY CERTIFY, That I attended deceased from

April 1 1936 to April 3 1936I last saw her alive on April 3 1936 Death is saidto have occurred on the date stated above, at 8:30 P.m.

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

Apoplexy

Date of onset

4/1/36

Other contributory causes of importance:

Heart failure
High blood pressure

Name of operation _____

Date of _____

What test confirmed diagnosis? _____

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? Yes

If so, specify _____

(Signed) _____

M. D.

(Address) Queencity MoJ. F. Jones

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.

OFFICE OF THE DIRECTOR OF PUBLIC HEALTH

STATE OF NEW YORK

1917

DEPARTMENT OF HEALTH

OFFICE OF THE DIRECTOR OF PUBLIC HEALTH

ALBANY, N. Y., JANUARY 15, 1917.

TO THE BOARD OF HEALTH OF THE CITY OF ALBANY:

RE: REPORT OF THE BOARD OF HEALTH OF THE CITY OF ALBANY, DATED JANUARY 10, 1917.

YOUR REPORT OF THE ABOVE ENTITLED MATTER HAS BEEN RECEIVED AND IS HEREBY ACKNOWLEDGED.

THE BOARD OF HEALTH OF THE CITY OF ALBANY IS ADVISED THAT THE BOARD OF HEALTH OF THE STATE OF NEW YORK HAS REVIEWED YOUR REPORT AND HAS ADVISED THAT IT IS IN FULL AGREEMENT WITH THE SAME.

IT IS THE POLICY OF THE BOARD OF HEALTH OF THE STATE OF NEW YORK TO ENCOURAGE THE BOARD OF HEALTH OF THE CITY OF ALBANY TO TAKE SUCH MEASURES AS MAY BE NECESSARY TO PREVENT THE SPREAD OF INFECTIOUS DISEASES.

YOUR COOPERATION IN THE MATTER OF THE ABOVE ENTITLED MATTER IS APPRECIATED.

VERY TRULY YOURS,

W. A. TAYLOR, Director of Public Health.

BY: _____

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY, N. Y., JANUARY 15, 1917.