

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.

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

Do not use this space.

13651

MAY 31 1935

1. PLACE OF DEATH

County Monticau  
Township Russian  
City Clarksburg (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward) \_\_\_\_\_

Registration District No. 1095  
Primary Registration District No. H 336

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

2. FULL NAME Mary Louise Bestgen

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 6 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
2 2 7

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at Home  
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) Dipton Mo.

13. NAME P. E. Bestgen

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

15. MAIDEN NAME Alma A Fischer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) California Mo.

17. INFORMANT P. E. Bestgen (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic burying DATE 4/24 1935

19. UNDERTAKER Louis S. Imhoff (ADDRESS) Dipton Mo.

20. FILED 4-20 1935 J. C. Martin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/23 1935

22. I HEREBY CERTIFY, That I attended deceased from 4-22 1935 to 4-23 1935

I last saw h. or alive on 4-23 1935 Death is said to have occurred on the date stated above, at 5:25 a.m.

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

Whooping Cough

Date of onset

Other contributory causes of importance:

Name of operation none 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) H. P. Baber M. D.  
(Address) California Mo

