

DEC 16 1937

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

6:45 P.M.
41151
Do not use this space.

1. PLACE OF DEATH

(a) County Douglas Registration District No. 272
(b) Township Beaumont Primary Registration District No. 5379 Registered No. 153
(c) City Ava mo (d) Street No. _____ St.
(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 Savie Ludwig

(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 15 1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elgie Ludwig

22. I HEREBY CERTIFY, That I attended deceased from Nov 5th, 1937, to Nov 15, 1937

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 8 1898

I last saw her alive on Nov-15, 1937. Death is said to have occurred on the date stated above, at 6:45 pm.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 0 7

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

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

Bronchial Pneumonia Date of onset Nov 13/37

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) Ava mo

Other contributory causes of importance: Abortion Nov 11 1937

13. NAME Anderson Iate

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Lucy Jackson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) Elgie Ludwig
Ava mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Ava mo DATE Nov. 16 1937

19. FUNERAL DIRECTOR (ADDRESS) C. V. Climbghard
Ava mo

20. FILED 12-8 19 37 Henry Burke Local Registrar

Name of operation _____ Date of _____
What test confirmed diagnosis? Examination Was there an autopsy? Yes

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 B.M. Norman M. D.
(Signed) Ava mo (Address)

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.

S. P. M. Norman

JUL 13 1957

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by
..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed

Licensed Embalmer No.

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

41157
Do not use this space.

1. PLACE OF DEATH

(a) County Douglas Registration District No. 272
 (b) Township Benton Primary Registration District No. 3379
 (c) City _____ (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.

Registered No. 153

2. PRINT FULL NAME

Davie Ludwig
 (a) Residence, No. Howie 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15 1937

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

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

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

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<u>39</u>	<u>0</u>	<u>7</u>	

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

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. Housewife
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (year) spent in this occupation

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER
 13. NAME

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER
 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide? _____ Date of injury _____, 19____

17. INFORMANT (ADDRESS)

Where did injury occur? _____ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE _____ DATE _____, 19____

Manner of injury _____

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury _____

20. FILED 12-8 1937 Henry Buske Local Registrar

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) R. M. Harman, M. D.

(Address) awa. mo.

SUPPLEMENTARY

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

Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified.

