

DEC 15 1939

Registration District No. 95

Primary Registration District No. 0141

Registrar's No. 12

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Cowgill
(c) Name of hospital or institution: 12
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 yrs (years, months or days) 11/1

3. (a) PRINT FULL NAME ALMEDA J. ALSPACH
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife H. H. Alspach Age of husband or wife if alive _____ years
7. Birth date of deceased APR 11 1855 (Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Wokee, Fairfield Co Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name LANTZ

18. Birthplace ALSACE LORRAINE FRANCE (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. Edlspach

(b) Address Cowgill, Mo.

17. (a) Burial, cremation, or removal Burial (b) Date thereof NOV 7, 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Cowgill Cemetery

18. (a) Signature of funeral director Chas. H. Reed

(b) Address Cowgill Mo

19. (a) Nov. 10, 1939 (Date received local registrar) (b) Mrs. M. D. Forbes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Caldwell
(c) City or town Cowgill (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5th year 1939 hour 3 minute 8 a.m.

21. I hereby certify that I attended the deceased from Sept. 15, 1939, 19____, to Nov. 5, 1939; that I last saw her alive on Nov. 7, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Coronary Thrombosis</u>	<u>Nov. 3, 1939</u>
<u>Cerebral Thrombosis</u>	<u>Nov. 4, 1939</u>
Due to <u>Chronic Myocarditis</u>	<u>years ago</u>
Due to <u>Generalized arteriosclerosis</u>	<u>years ago</u>

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations none A.C.

Of autopsy none

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Edlspach (M. D. or other)

Address Polo, Mo. Date signed 11/5/39

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.

1939

RECEIVED
District Health Officer No. 11,
District No. 1239-1694
Date Filed DEC 14 1939

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, or by _____

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

Signed *C. Reed*
Licensed Embalmer No. *2194*
P. O. Address *Council Bluffs*

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.