

JAN 17 1946

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

43089  
Do not use this space.

1. PLACE OF DEATH *Clark 2*  
 (a) County *Clark* Registration District No. *189*  
 (b) Township *Vernon* Primary Registration District No. *3263* Registered No. \_\_\_\_\_  
 (c) City *Alexandria* (d) Street No. *5112* 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.  
*6 3 5* *E. L. Breitenbuecher*  
 2. PRINT FULL NAME \_\_\_\_\_  
 (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

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Resuming*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 23 - 1907*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*77 10 4*  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Merchant*  
 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) *Alexandria Mo*

FATHER 13. NAME *Geo Breitenbuecher*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alesse Luvaine Norway*

MOTHER 15. MAIDEN NAME *Margret Meyer*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alesse Luvaine Norway*

17. INFORMANT (ADDRESS) *Wanda Breitenbuecher Alexandria Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Brunswick La* DATE *Dec 29 39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *H. K. Kisch Wayland Mo*

20. FILED *25* 19*39* *Dr FAS Rebo* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 27 1939*  
 22. I HEREBY CERTIFY, That I attended deceased from *Dec 24 1939* to *Dec 27 1939*  
 I last saw him alive on *Dec 27 1939*. Death is said to have occurred on the date stated above, at *4:45 P.M.*  
 The principal cause of death and related causes of importance were as follows:

*Cerebral Hemorrhage*  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: *g.f.p.*

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) *FAS Rebo*, M. D.  
 (Address) *Alexandria Mo*

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.

RECEIVED

District Health Officer No. 16

District File Number 1-40-182

Date Filed JAN 13 1940

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,

H. F. Kircher

, or by

Registered Apprentice No. 2611, working under my personal supervision.

Signed

H. F. Kircher

Licensed Embalmer No.

2611

P. O. Address

Wayland M.

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

43089

Do not use this space.

1. PLACE OF DEATH  
 (a) County Clark Registration District No. 189  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4112 Registered No. \_\_\_\_\_  
 (c) City Alexandria 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.

2. PRINT FULL NAME Ernestus L. Breitenbuecher  
 (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

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Wid</u> <small>(write the word)</small>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>72</u>	MONTHS <u>10</u>	DAYS <u>4</u>	If LESS than 1 day, _____ hrs. or _____ min.
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.			
	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)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE _____ DATE _____ 19__				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED <u>Dec 30, 1939</u> <u>Dr. F. A. S. Rebo</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h\_\_\_\_\_ 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 F. A. S. Rebo, M. D.  
 (Signed) \_\_\_\_\_ (Address) Alexandria, Mo

SUPPLEMENTARY

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

Corrected or amended statements must contain, so that it may be properly classified. Exact statement of OCCUPATION is very important.

