DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3155

Registration District No. 601 — Primary Registration District No. 5796 — Registrar's No. One

1. PLACE OF DEATH:

(a) County Morgan

(b) City or town Near Florence (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan

(c) City or town Near Florence, Mo. (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.

3. (a) PRINT FULL NAME August Christian Ehrke

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of ~~husband~~ or wife Sophia 65 years

6. (c) Age of ~~husband~~ or wife if alive years

7. Birth date of deceased Apr (Month) 10 (Day) 69 (Year)

8. AGE: Years 70 Months 9 Days 2 If less than one day hr. min.

9. Birthplace Pyrmont (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name August Ehrke
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Monsees
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lena Brauer

(b) Address Mora Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-40 (Month) (Day) (Year)

(c) Place: burial or cremation Florence Mo

18. (a) Signature of funeral director A. F. Neumeyer

(b) Address Smithton Mo

19. (a) Jan 14, 1940 (Date received local registrar) (b) Mrs. Arthur Schroeder (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12 year 1940 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from 1-5-40, 19__, to 1-12-40, 19__; that I last saw him alive on 1-12-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Chron Myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature L. J. Holzin (M. D. or other)

Address Smithton Mo Date signed 1/12/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

I X19511

RECEIVED
District Health Officer No. 7,
District File Number 2-40-233
Date Filed 2-13-40

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed A. F. Nemeyer

Licensed Embalmer No. 3912

P. O. Address Smithton Mo

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

3153

Do not use this space.

1. PLACE OF DEATH

(a) County: Morgan — Registration District No.: 601

(b) Township: Richland — Primary Registration District No.: 2796 — Registered No.:

(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.

2. PRINT FULL NAME: August Christian OEHRIE

(a) Residence, No. St.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): M

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

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

7. AGE — YEARS: 70 — MONTHS: 9 — DAYS: 2 — 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 Jan 14, 1940 Mrs Arthur Schroder *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 12, 1940

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

I last saw him 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 .....

(Signed) E. B. Holtzen, M. D.

(Address) Smithton Mo

SUPPLEMENTARY

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.

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

S-3155