

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

7909  
Do not use this space.

FILED MAR 11 1940

1. PLACE OF DEATH

(a) County Ray Registration District No. 744  
(b) Township Richmond Primary Registration District No. 3035  
(c) City Richmond (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. da. How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Lena C. Kalbeiloh  
(a) Residence, No. N. Main St. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 26-1864  
7. AGE YEARS 75 MONTHS 5 DAYS 1 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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 (years) spent in this occupation \_\_\_\_\_

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

13. NAME Phillip Herrmann

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

15. MAIDEN NAME Mary Steinhilber

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

17. INFORMANT Charles Kalbeiloh (ADDRESS) Richmond Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cem. DATE 1-29-40

19. FUNERAL DIRECTOR (NAME) A. W. Mann (ADDRESS) Richmond Mo.

20. FILED Mar. 6 19 40 Matth. Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 27<sup>th</sup> 1940

I HEREBY CERTIFY, that I attended deceased from Jan 20 to Jan 27, 1940, last saw her alive on Jan 27, 1940. Death is said to have occurred on the date stated above, at 3 a. m. The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis

Other contributory causes of importance: Nephritis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) E. E. Jay M. D.

(Address) Richmond Mo.

WRITE PEANILY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. E.—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.

1 X18605

932

RECEIVED  
District Health Officer No. 8,  
District File Number  
31740  
Date filed

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.....

..... *A. W. Maurer* ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed..... *A. W. Maurer* .....  
Licensed Embalmer No. *1317*  
P. O. Address..... *Richmond Md* .....

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7909

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 744

Primary Registration District No. 3035-

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Richmond  
(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  
In this community.....  
years, months or days)

3. (a) **PRINT FULL NAME** Lena a Kalberloh

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race W  
6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.  
75 5 1

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (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 Jan day 27  
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....  
that last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myo Carditis

Due to..... 131  
Due to.....

Other conditions (include pregnancy within month of death)

reflected Chronic

Major findings: Of operations..... no

Of autopsy..... no

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 E. F. Gay (M. D. or other)

Address Richmond Date signed.....

SUPPLEMENTAL

Duration  
Underline the cause to which death should be charged statistically.

