

Registration District No. **7994**

Primary Registration District No. **6037B**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County Saline, Crawford  
(b) City or town Slater, Mo., RFD#3.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: X  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
In this community 77 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bertha Charlotte Reidenbach.

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

4. Sex Female. 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased September-6-1841.  
(Month) (Day) (Year)

8. AGE: Years 98 Months 5 Days 9 If less than one day hr. X min.

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

10. Usual occupation General House Work.

11. Industry or business None X

12. Name John Steffen.

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

14. Maiden name Don't know

15. Birthplace Don't know Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature B. E. Reidenbach

(b) Address Slater Mo RFD#3

17. (a) Burial, (burial, cremation, or removal) Burial. (b) Date thereof 2-18-40.  
(Month) (Day) (Year)

(c) Place: burial or cremation Neu Frankfort, Mo.

18. (a) Signature of funeral director John A. Stagle

(b) Address Slater Mo

19. (a) (Date received local registrar) 7-27-40 (b) (Registrar's signature) [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Slater, Mo., RFD#3. Rural  
(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.? 93c years. years.

MEDICAL CERTIFICATION 15

20. DATE OF DEATH: Month February day 15  
year 1940 hour 10.00 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 3-7-39. 19\_\_\_\_ to 3-7-39. 19\_\_\_\_;  
that I last saw her alive on 3-7-39. 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death From History  
Nyctephalic Pneumonia Duration 2 days

Due to Influenza, acute 11/15 5 days

Due to The statement from History of relatives

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence none

(c) Where did injury occur? (City or town) (County) (State) none

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work no (Specify type of place) (e) Means of injury no

23. Signature B. E. Reidenbach (M. D. or other) no

Address Slater Mo Date signed 7/27/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Rev. 5-17-39

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.

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RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 3-13-42

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

Licensed Embalmer No. 3143

P. O. Address Littleton

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.

Registration District No. 799

Primary Registration District No. 603713

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Splaine  
(b) City or town Cambridge Jno.  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

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.

3. (a) PRIMA FIDELIA

Bertha Charlotte Reidenbach

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

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
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 98 Months 5 Days 9 If less than one day \_\_\_\_\_ min.

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) 2 16 (b) W. M. Tuttle  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 15  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 H. E. Lockwood (D. or other) \_\_\_\_\_  
Address slater mo Date signed \_\_\_\_\_

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

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

SUPPLEMENTAL

