

APR 25 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10897

Registration District No. 300

Primary Registration District No. 5417

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Rural, Lyon Sup  
(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) 2

(d) Length of stay: In hospital or institution 2  
(Specify whether

In this community Life  
years, months or days)

3. (a) PRINT FULL NAME Fritz W. Kormeier

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

alive \_\_\_\_\_ years

7. Birth date of deceased June 24, 1857  
(Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Joseph Kormeier

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

14. Maiden name Mrs. Lueker

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

16. (a) Informant Lynn Kormeier

(b) Address Leslie Mo

17. (a) Burial (b) Date thereof March 25, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Ep. Cem.

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

(b) Address Beaufort Mo

19. (a) 3-24-40 (b) H. Matthews  
(Date received in registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town Rural, Lyon Sup  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Leslie Rural Route  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22  
year 1940 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from 3-10, 1940, to 3-22, 1940

that I last saw him alive on 3-22, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Epilepsy Duration 12 da.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Nephritis  
(Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

27. While at work \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature H. Matthews (M. D. Beaufort Mo)

\*Address Beaufort Mo Date signed 3-24-40

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

MOTHER FATHER

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

*E. H. Termmel*

Registered Apprentice No.

working under my personal supervision.

Signed

*E. H. Termmel*

Licensed Embalmer No.

*3076*

P. O. Address

*Beaufort N.C.*

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.