

Registration District No. 532

Primary Registration District No. 4318

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town La Plata Mo  
(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 5-14 years

3. (a) PRINT FULL NAME Henry F. Minkelman

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 Married

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

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

7. Birth date of deceased Nov. 5 - 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>4</u>	<u>2</u>	hr. _____ min. _____

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

10. Usual occupation Business

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

12. Name John Minkelman

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

14. Maiden name Elizabeth Minkelman

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

16. (a) Informant Marion F. Minkelman

(b) Address La Plata, Mo

17. (a) Burial (b) Date thereof 3-10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Plata Mo

18. (a) Signature of funeral director W. A. Ripper

(b) Address Belleville Mo

19. (a) Mar 9, 1940 (b) Louise J. Smith  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State La Plata (b) County Macon

(c) City or town La Plata 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 7,  
year 1940 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb.  
25, 1940 to Mar. 7, 1940  
that I last saw him alive on Mar. 7, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia  
Influenza

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

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

Other conditions (Include pregnancy within 5 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? 475

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Carl P. Sweeney (M. D. or other) \_\_\_\_\_

Address La Plata Mo Date signed \_\_\_\_\_

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

61  
6  
0

RECEIVED

District Health Officer No. 10

District File Number 4-40-701

Date Filed APR 4 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, or by.....

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

working under my personal supervision.

Signed *E. E. Hopper*

Licensed Embalmer No. 878

P. O. Address.....

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.

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(a) County Macon  
(b) City or town Laplata mo  
(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 of days)

3. (a) PRINT FULL NAME Henry F. Swinkelman  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 2 If less than one day \_\_\_\_\_ h \_\_\_\_\_ 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 \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) Mar 9, 1946 (b) Mrs. Louise Smith (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 Mar day 7 year 1946 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 \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature C. H. Buckley (M. D. or other) \_\_\_\_\_  
Address Laplata mo Date signed \_\_\_\_\_

SUPPLEMENTAL

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

11630 (1940)