

Registration District No. **186** Primary Registration District No. **5075** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Bates**
 (b) City or town **Rural Charlotte Twp**
 (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 **5711**

3. (a) PRINT FULL NAME **Mrs Bertha Engelhardt**
 3. (b) If veteran, name war **E**
 3. (c) Social Security No. _____

4. Sex **female**
 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife **Herman Engelhardt dec.**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct 2 1859**
 (Month) (Day) (Year)

8. AGE: Years **80** Months **5** Days **28**
 If less than one day _____ hr. _____ min.

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

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **David Glass**
 18. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

14. Maiden name **not known**
 15. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Fred Koch**
 (b) Address **Amoret Mo**

17. (a) **burial** (b) Date thereof **March 21 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wak Hall**

18. (a) Signature of funeral director **Culver**
 (b) Address **Buller Mo**

19. (a) **March 1940** (b) **Ther...**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Bates**
 (c) City or town **Rural Charlotte Twp.**
 (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 **March** day **20**
 year **1940** hour **12:15** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **May 1939**, 19____, to **Nov 20 1940**
 that I last saw him alive on **Nov 20 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of right breast**
 Due to **and lung**

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? _____

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

23. Signature **L. D. La Haru** (M. D. or other) **Med**
 Address **Buller Mo** Date signed **4/15/40**

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

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

538

RECEIVED Officer No. 7,
District Health 5-40-715
District File Number 5-6-40
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~~

....., Registered Apprentice No.

working under my personal supervision.

Signed B. Linton Lisle

Licensed Embalmer No. 4123

P. O. Address Butler, 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.

Registration District No. 186

Primary Registration District No. 5078

Registrar's No. _____

1. PLACE OF DEATH

(a) County Bates

(b) City or town Charlotte Ins
(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

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) PR Miss Bertha Engelhardt
FUL

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20 year 1990 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.

4. Sex F

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)

Immediate cause of death _____

8. AGE: Years 80 Months 5 Days 18 If less than one day _____ h. _____ min.

Due to _____

Due to _____

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

Other conditions: (Include pregnancy within 3 months of death) _____

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mar 21 (b) C. A. Rusik
(Date received local registrar) (Registrar's signature)

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) _____ (c) Means of injury _____

23. Signature L. D. Rastue (M. D. or other) _____

Address Bates Ins Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14227
Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 186

Primary Registration District No. 3078

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

1. PLACE OF DEATH:
(a) County Bates
(b) City or town Charlotte, Mo
(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
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) PRINT FULL NAME Mrs Bertha Tugdhaert
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Mar day 20 year 1950 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.

4. Sex F 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..... year.....

Immediate cause of death Carcinoma of breast and lung
Due to Primary seat
Due to Right mammary gland

7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
80 6 18 hr..... min.....

Other conditions (Include pregnancy within 3 months of death) 50
Major findings:
Of operations.....
Of autopsy.....

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation.....
11. Industry or business.....

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

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....
19. (a) (Date received local registrar) (b) (Registrar's signature)

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) (c) Means of injury.....
23. Signature L. D. La Hue (M. D. or other).....
Address Center, Mo Date signed.....

SUPPLEMENTAL