

2  
0-39  
39  
21482

MAY 13 1940  
Registration District No. 20

Primary Registration District No. 5574

Registrar's No. 44

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

**1. PLACE OF DEATH:** Jefferson

(a) County: Jefferson

(b) City or town: Blackwell VALLE

(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: Not 40 years (Specify whether years, months or days)

In this community \_\_\_\_\_ years, months or days

**3. (a) PRINT FULL NAME:** Barbara Steinmetz 353

(b) If veteran, name war: \_\_\_\_\_ (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: Dr. F.R.B. Steinmetz 6. (c) Age of husband or wife if alive: deceased years

7. Birth date of deceased: Feb. 4, 1857 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
83	2	6	hr. min.

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

10. Usual occupation: housewife

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

**MOTHER FATHER**

12. Name: John Fischer

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

14. Maiden name: Eva Speck

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

16. (a) Informant: J.B. Steinmetz (b) Address: Clarkston Mo

17. (a) burial (b) Date thereof: Sat April 13 1940 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director: Lee Mothershead (b) Address: DeSoto Mo.

19. (a) 5-9-40 (Date received local registrar) (b) Geneva Donnell (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Jefferson

(c) City or town: Blackwell (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.: About 25 65 years

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 10 year 1940 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from 4-8 1940 to 4-10 1940 that I last saw h. ev. alive on 4-10 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Hemorrhage 4-8-40 Duration 4-8-40

Due to: ?

Due to: ?

Other conditions: ?

(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? \_\_\_\_\_

381

23. Signature: \_\_\_\_\_ (M. D. or other) \_\_\_\_\_ Date signed: 4/12/40

27

EX-67  
08-10-51  
WOM

**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.....

.....  
working under my personal supervision.

Signed *J. E. Mothrushead* Registered Apprentice No. ....

Licensed Embalmer No. *3521*

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15247

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 420

Primary Registration District No. 5374

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Waller, 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

3. (a) PRINT FULL NAME Barbara Steinmetz

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

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) \_\_\_\_\_

8. AGE: Years 83 Months 2 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(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 apr day 10 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 Pulmonary embolism Duration \_\_\_\_\_

Due to Essential Hypertension

Due to Chr. Arthritis

Other conditions (such as pregnancy within 3 months of death) Essential Hypertension

Major findings: Chr. Arthritis

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? \_\_\_\_\_

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

23. Signatur Pros E Fallet (M. D. or other) \_\_\_\_\_

Address Beato Date signed \_\_\_\_\_

SUPPLEMENTAL

