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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MAY 2 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16368

State File No. _____

Registration District No. 877

Primary Registration District No. 4530

Registrar's No. 6-

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Schell City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
In this community 6 years
years, months or days (Specify whether)

8. (a) PRINT FULL NAME Herrmann Henry Dieckbreder

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

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

6. (b) Name of husband or wife Daisy M Dieckbreder 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased April 12 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 25
If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name William Dieckbreder

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

14. Maiden name Catharina Meyer

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

16. (a) Informant Delia Dieckbreder

(b) Address Schell City Mo

17. (a) Burial (b) Date thereof April 9, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Antoine's & Son

(b) Address Schell City Mo

19. (a) April 7-40 (b) Charles Kayser
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon
(c) City or town Schell City 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 April day 7
year 1940 hour 7:30 minute 9 M.

21. I hereby certify that I attended the deceased from June 7-1938
April 7 1940 to _____ 19____
that I last saw him alive on April 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus
Died suddenly

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration 4 yrs
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? no (Specify type of place) (e) Means of injury? _____

23. Signature JR Colson (M. D. or other) _____
Address Schell City Mo Date signed 4-8-40

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 _____

Registered Apprentice No. _____

~~working under my personal supervision.~~

Signed

Marion M. Lewis

Licensed Embalmer No. *3084*

P. O. Address *Shell City, 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.

No. 2B
2-21-40
I X22559

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16368

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 827

Primary Registration District No. 4530

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Vermon

(b) City or town Schell City
(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 Herman Henry Dickbrader

3. (a) PRINT FULL NAME Hermann Henry Dickbrader

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, und

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 Months Days If less than one day

71 11 25- hr. 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Apr. 9-1948 (b) Pearle Rappas
(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.

20. DATE OF DEATH Month Apr day 7 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. P. Colson (M. D. or other) _____
Address Schell City Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

