

Registration District No. 124

Primary Registration District No. 4070

Registrar's No. 16

1. PLACE OF DEATH: Cape Girardeau
 (a) County _____
 (b) City or town Jackson Mo.
 (c) Name of hospital or institution: _____
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution _____
 In this community 75 years
 years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Cape Girardeau
 (c) City or town Jackson Mo
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A.? Life years.

3. (a) PRINT FULL NAME LOUISA OBERMILLER 165
 8. (b) If veteran, name war _____ 9. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 11
 year 1940 hour 6 minute P M.
 21. I hereby certify that I attended the deceased from March 2
1939, to May 11, 1940
 that I last saw her alive on May 11, 1940
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Theodore Obermiller
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Mar. 16 1854
 (Month) (Day) (Year)

Immediate cause of death Carcinoma face Duration 6 mo

8. AGE: Years 88 Months 1 Days 25
 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions None
 (include pregnancy within 3 months of death)

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Michael Bausancourt
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Barbara Heft
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. H. Obermiller
 (b) Address Jackson Mo.

17. (a) Burial (b) Date thereof May 13 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Jackson Cemetery

18. (a) Signature of funeral director Miller
 (b) Address Jackson Mo

19. (a) 5-13440 (b) B. G. Subert
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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 H. J. DeYoung (M. D. or other) _____
 Address Jackson Mo Date signed 5-13-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

52

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 Lyman Stebbins

Licensed Embalmer No. 2476

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 18089

Registration District No. 124

Primary Registration District No. 4070

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Jackson
(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) PRINT FULL NAME Louise Obermiller

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 88 Months 1 Days 25 If less than one day _____ 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) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11
year 1940 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 Carcinoma

Due to one 1/2 inch circle of fecal
2 inches under eye

Other conditions _____ (Include pregnancy within 3 months of death) 5 1/2

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 D. J. L. Seabough (M.D. or other) _____

Address Jackson Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

HOWENA

S-18089