

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

18320
Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade Registration District No. 304
 (b) Township 2 Primary Registration District No. 5421
 (c) City Gasconade (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 50 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 65 yrs. mos. ds.

2. PRINT FULL NAME BERTHA JACKISCH

(a) Residence, No. Gasconade, Missouri St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles Jackisch
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 9, 1858
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
81 11 6

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. rwf
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) 1/40
 11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER 13. NAME Unkown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Unkown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Fred Jackisch
 (ADDRESS) Gasconade, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Gasconade City Cem. DATE _____ 19____

19. FUNERAL DIRECTOR (NAME) Hugo H. Blumer
 (ADDRESS) Hermann, MO

20. FILED 6-7 1940 F. E. Kieker
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19____
 22. I HEREBY CERTIFY, That I attended deceased from 2-12- 1940, to 3-13- 1940
 I last saw her alive on 3-10- 1940 Death is said to have occurred on the date stated above, at 3 p.m.
 The principal cause of death and related causes of importance were as follows:

Pericarditis
Cardiac Decomposition
 Date of onset _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) W. V. McFarrell, M. D.
275 (Address) Chambers Mo

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.

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.....

Hugo B. Bunn

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.