

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.

FILED JUL 1 1940

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

21711

Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade 2 Registration District No. 304
(b) Township Hickland 0 Primary Registration District No. 5421 Registered No. 55
(c) City Hermann (d) Street No. Hermann, Missouri RFD St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 78 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 62 SANNA MARIA FRECHMANN

(a) Residence, No. Hermann, Missouri RFD 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Anthony Frechmann</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>6/40</u> ✓		
7. AGE	YEARS	MONTHS
	<u>79</u>	<u>4</u>
		DAYS
		<u>7</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>nwf.</u>	
	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) <u>6/40</u>	11. Total time (years) spent in this occupation <u>55</u>
12. BIRTHPLACE (CITY OR TOWN) <u>Hermann</u> 0 (STATE OR COUNTRY) <u>Missouri</u>		
FATHER	13. NAME <u>Gottfried Mupp</u> 6	
	14. BIRTHPLACE (CITY OR TOWN) <u>Germany</u> (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>Magdalena Dolores</u> 6	
	16. BIRTHPLACE (CITY OR TOWN) <u>Germany</u> (STATE OR COUNTRY)	
17. INFORMANT <u>Mrs. Laura Ameling</u> (ADDRESS) <u>Hermann, Missouri</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Frechmann Farm Cem.</u> <u>6/20/40</u>		
19. FUNERAL DIRECTOR (NAME) <u>HUGO H. BLUMER</u> (ADDRESS) <u>Hermann, Missouri</u>		
20. FILED <u>6-28</u> 19 <u>40</u> <u>S. R. Kicker</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 17, 1940

22. I HEREBY CERTIFY, THAT I attended deceased from

Nov. 29, 1938, to June 17, 1940I last saw h. alive on June 14, 1940. Death is saidto have occurred on the date stated above, at 5:50 P.M.

The principal cause of death and related causes of importance were as follows:

Gangrene of lungDate of onset
6/12/40

Other contributory causes of importance:

Portic insufficiency
Gangrene of st. legP
6/17/40Name of operation Stethoscope Date of noWhat test confirmed diagnosis? Stethoscope Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury no, 19noWhere did injury occur? no
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury noNature of injury no24. Was disease or injury in any way related to occupation of deceased? noIf so, specify no(Signed) W. A. Peter D.O.Hermann, Mo.
275 (Address)

922

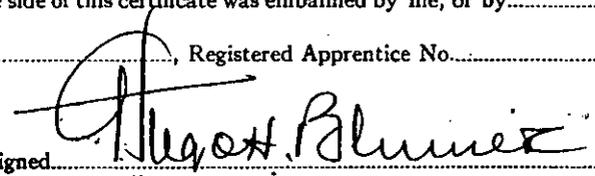
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 3160.....

P. O. Address Hermann, Missouri.....

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. 21711
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 304

Primary Registration District No. 5421

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

1. PLACE OF BIRTH:

(a) County Essex
(b) City or town Richland, S.C.
(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 _____
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

Auna Maria Frenchman

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 _____ year

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 7 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)

(Burial, cremation, or removal)

(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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Embolus from gangrenous leg

Due to _____

Due to _____

Other conditions: asthma, insufficient
(Include pregnancy within 3 months of death)

Major findings: Gangrene of Rt. leg

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. Signature: W. A. Jeter M. D. (Other) _____

Address: Herndon Date signed _____

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21711

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 314

Primary Registration District No. 5421

Registrar's No.

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

1. PLACE OF BIRTH:

(a) County Boonville

(b) City or town Richland, 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

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 Anna Maria Freuchmann

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH Month June day 17 year 1940 hour _____ minute _____ M.

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.

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 _____

7. Birth date of deceased Feb 10 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 7 If less than one year, _____ hr. _____ amin.

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 Hugh H. Blume

(b) Address Hermann, Mo

19. (a) 6-28-40 (b) F. K. Kicker
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature H. A. Jeter (M., D. or other) _____

Address Hermann _____

SUPPLEMENTARY COPY