

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23026**

Registration District No. **16** Primary Registration District No. **6649** Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **Texas**
(b) City or town **Sherrill**
(c) Name of hospital or institution: **none**
farm
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution **2**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Barbara Zehnder**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 12 1852**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 9 15 hr. min.

9. Birthplace **Switzerland** **Thurgau**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Anton Bausch**
13. Birthplace **Switzerland**
(City, town, or county) (State or foreign country)
14. Maiden name **Katharina Zehnder**
15. Birthplace **Prunana**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **John House**

(b) Address _____
17. (a) **Burial** (b) Date thereof **6-27-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Shady Grove**

18. (a) Signature of funeral director **Smith & Yenson**
(b) Address **Lubbock, TX**

19. (a) **6-27-40** (b) **W. H. Reed**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Texas** (b) County **Texas**
(c) City or town **rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Looking R Road**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **60** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **27** year **1940** hour **5** minute _____ M.

21. I hereby certify that I attended the deceased from **June 1, 1937** to **June 27, 1940** that I last saw her **alive** on **June 22, 1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Thrombosis** **Neuritis** **320**
Duration

Due to _____

Due to **121**

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? **776**

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

23. Signature **W. H. Reed** (M. D. or other) _____

Address **Lubbock, TX** Date signed **6/27/40**

Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

RECEIVED
District Health Officer No. 5

Signed.....

District File Number 280 254

Licensed Embalmer No.....

Date Filed 7/1/40

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.