DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23103

Registration District No. [illegible]

Primary Registration District No. 6200

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Webster

(b) ~~City or town~~ rural - High Prarie township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: x
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution x (Specify whether
In this community 15 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

(c) City or town rural - High Prarie
(If outside city or town limits, write "RURAL")

(d) Street No. x x
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 55 years years.

3. (a) PRINT FULL NAME Alois Jaich

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dora

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased June (Month) 21, (Day) 1861 (Year)

8. AGE: Years 78 | Months 6 | Days 11 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name John Jaich
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ? Mortimer
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rufus Alexander

(b) Address Marshfield, Missouri.

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof Jan. 3, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Black Oak

18. (a) Signature of funeral director Rex Rainey

(b) Address Marshfield, Missouri.

19. (a) Apr. 15 - 40 (Date received local registrar) (b) Elizabeth Highfire (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~[illegible]~~ January day 2
year 1940 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from ~~Feb. 20 - 1939~~ Dec. 20 - 1939, to ~~March 2~~ Jan 2 - 40 ~~1940~~
that I last saw him alive on Jan 2, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Double Lobar Pneumonia fever	
Due to	
Due to Fractured left hip and left arm	
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?
824 (Specify type of place)
While at work? (e) Means of injury

23. Signature W. F. Schlicht (M. D. or other)
Address Nimrod MO Date signed 3-1-40

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 6,
District File Number 640 - 1440
Date Filed JUN 20 1940

1941
99

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi 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 X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23103

Registration District No. 896 Primary Registration District No. 6200 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Webster

(b) ~~City or town~~ High Prairie T.P.
(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 Alois Jaich

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 m

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	Months	Days	If less than one day
78	6	11	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2
year 1940 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 Double Lobar Pneumonia

Due to 1 Mo 18

Due to

Other conditions Fracture left hip and left arm
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) accident
(b) Date of occurrence Dec-1-1939
(c) Where did injury occur? Her own Porch. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? She fell off her Porch at Home (Specify type of place)
While at work? (e) Means of injury

23. Signature W. F. Schlicht (M. D. or other)
Address Niangua Mo