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SEP 25 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29478

Registration District No. 150

Primary Registration District No. 4451

Registrar's No. 1697

1. PLACE OF DEATH:  
(a) County Ripley  
(b) City or town Doripshaw, Mo.  
(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 2  
(Specify whether  
In this community 55 years  
years, months or days)

3. (a) PRINT FULL NAME MIKE HENGLER 574  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Marie Hengler 6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased May 10 1856  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>3</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation farmer  
11. Industry or business 9

12. Name unknown 9  
13. Birthplace (City, town, or county) (State or foreign country) 9  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Marie Hengler  
(b) Address Doripshaw, Mo.

17. (a) Burial (b) Date thereof 9-1-'40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Plunk

18. (a) Signature of funeral director Blackie Martney  
(b) Address Doripshaw, Mo. 2-7th St.

19. (a) 9-2-40 (b) E. B. Johnston  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Ripley  
(c) City or town Doripshaw  
(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.? 58 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 12th  
year 1940 hour 2 minute 15 A. M.  
21. I hereby certify that I attended the deceased from June 15th  
\_\_\_\_\_, 1940, to 8/31/1940,  
that I last saw him alive on 8/31/1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Toxemia 3 days

Due to Cancer of prostate and bladder

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)

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?  
674 (Specify type of place)  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Edw. Johnson (M. D. or other) \_\_\_\_\_  
Address Doripshaw, Mo. Date signed 9/2/40

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

Duration  
3 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29478**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **750**

Primary Registration District No. **4457**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Ripley**  
(b) City or town **Stoniflan**  
(If outside city or town limits, give street, lot or block, 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

**Miss Hengler**

(b) If veteran, \_\_\_\_\_ (c) Social Security name war \_\_\_\_\_ 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  
**84 3 21** \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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. (c) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 **Sept** day **1**  
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 **Wernicke's Toxemia**  
**Cancer of prostate and bladder**  
Due to **primary focus of malignancy prostate gland.**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations **51**  
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 **J. Edw. Adamson** (M. D. examiner)  
Address **Stoniflan, Mo.** Date signed **10-23-40**

Duration  
**5 yrs**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

