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OCT 23 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32852

Registration District No. 679

Primary Registration District No. 5907

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town ~~Phelps~~ Viola  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1717 1/2  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Phelps

(c) City or town Viola mo  
(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 Karolina Herberger

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1940 hour 20 minute \_\_\_\_\_ A.M.

4. Sex F 5. Color or race wh

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

6. (b) Name of husband or wife Raymond Herberger

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

7. Birth date of deceased June 26 1853  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1, 1939 to July 26, 1940  
that I last saw her alive on July 26, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 87 Months 1 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

Immediate cause of death menia ✓

Duration
<u>1 wk</u>
<u>2 yrs</u>
<u>40 yrs</u>

Due to chronic myocarditis with congestive failure

Due to mitral stenosis

10. Usual occupation Home

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

MOTHER FATHER

12. Name Valentina Barak

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

14. Maiden name Barbara Herberger

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

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.

16. (a) Informant Henry Herberger

(b) Address Viola mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 1940  
(Month) (Day) (Year)

(c) Place: burial or cremation Beaver Dam

18. (a) Signature of funeral director Paul

(b) Address Rolla mo

19. (a) Aug. 4, 1940 (Date received local registrar) (b) Jon. F. Ayers (Registrar's signature)

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? 610

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

23. Signature E. E. Feind M.D. (M. D. or other) \_\_\_\_\_

Address Box 534 Rolla mo Date signed 7-31-40

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

RECEIVED

District Health Officer No. 5,

District File Number 1040 980

Date Filed \_\_\_\_\_

92W

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 S. L. Miller

Licensed Embalmer No. 3397

P. O. Address Rolla, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32852**  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
Registration District No. **679**

Primary Registration District No. **2909**

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

1. PLACE OF DEATH:

(a) County **Phelps Spring Twp.**  
(b) City or town **Phelps Spring Twp.**  
(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)

3. (a) PRINT FULL NAME **Karoline Kerberger**

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 \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years **87** Months **1** Days **0** 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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **July** day **26**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 **uremia**

Due to **Chc. myocarditis with congestive failure**

Due to **mitral stenosis**

Other conditions **Chc. nephritis**  
(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) \_\_\_\_\_

(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 **E. E. Fend** (M. D. or other) \_\_\_\_\_

Address **Rolla Mo** Date signed \_\_\_\_\_

SUPPLEMENTAL

