

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 38493Registration District No. 197Primary Registration District No. 5276

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay,
 (b) City or town Claycoma, Liberty Route #2
 (If outside city or town limits write "RURAL" and name of township)
Rural, Gallatin Township
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no.
 In this community 60 days, (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME Miss Caroline Heilert,3. (b) If veteran, name war no. 3. (c) Social Security No. no.4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single,6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years7. Birth date of deceased April 10 1859
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
81 7 8 hr. min.9. Birthplace Missouri, (State or foreign country)10. Usual occupation at home, (City, town, or county) (State or foreign country)11. Industry or business X12. Name August Heilert,13. Birthplace Germany, (State or foreign country)14. Maiden name Caroline Mullmeirer, (City, town, or county) (State or foreign country)15. Birthplace Germany, (City, town, or county) (State or foreign country)16. (a) Informant's own signature Elizabeth Haysler,(b) Address Claycoma, Mo., R. F. D. #2.17. (a) Removal (b) Date thereof 11-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hermann, Mo.18. (a) Signature of funeral director Stine & McClure,(b) Address 3235 Gillham Plaza, K. C., Mo.19. (a) Nov 19, 1940 (b) John S. Morton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Clay,
 (c) City or town Rural Gallatin
 (If outside city or town limits, write "RURAL")
 (d) Street No. Liberty Route #2
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? no. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 18th,
year 1940 hour 9:15 minute P. M.21. I hereby certify that I attended the deceased from Nov 1
1940, to Nov 18, 1940that I last saw her alive on Nov 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchopneumonia

Duration

Due to _____

Due to _____

Other conditions Senility, Jumbled
(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? _____

963 (Specify type of place) _____
While at work? (e) Means of injury _____23. Signature M. J. Longhus (M. D. or other) !
Address As Kansas City, Mo. Date signed 11-18-40

DEC 18 1940

10-7-12

Dr. Langhus, No. K. C., Mo.

Date Filed 12-18-40
District File Number
Number No. 8

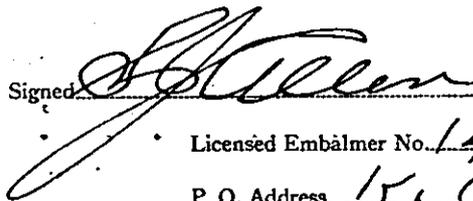
STATEMENT BY LICENSED EMBALMER

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. 1415

P. O. Address K. C., 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. 38493

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 197

Primary Registration District No. 2276

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Osage
(b) City or town Wasson 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 _____ (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 Caroline Heilert

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 5

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 81 Months 7 Days 8 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)

(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 11 day 18 year _____ 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 Broncho Pneumonia Duration _____

Due to _____ 4/6

Due to _____

Other conditions Senility, Jaundice (Include pregnancy within 3 months of death.)

Major findings: Putrid decomposition of soft tissue PHYSICIAN _____

Of operations _____

Of autopsy no autopsy 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 _____ (M. D. or other) _____

Address _____ signed 1-27-41

SUPPLEMENTARY

