

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

REC'D APR 28 1941

Registration District No. 388

Primary Registration District No. 5542

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Haskell

(b) City or town Deane Valley Mo

(c) Name of hospital or institution: Sisson Twp

(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____

In this community Twenty Eight years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Haskell

(c) City or town Rural

(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. 0 years.

3. (a) PRINT FULL NAME Maria Ginkle

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4

year 1941 hour 6⁵⁵ minute _____ P. M.

4. Sex female

5. Color or race white

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

(b) Name of husband or wife Benjamin Ginkle

(c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 1854

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-22, 1941, to 3-4, 1941;

that I last saw her alive on 2-22, 1941; and that death occurred on the date and hour stated above.

8. AGE: Years 87 Months - Days 23

If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to _____

9. Birthplace Lancaster Co. Pa.

(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions Erysipelas of face

(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER

12. Name Aaron H. Brakaker

13. Birthplace Pa.

(City, town, or county) (State or foreign country)

14. Maiden name Mary Anna Snyder

15. Birthplace Pa.

(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature P. L. Fike

(b) Address West Plains, Mo.

17. (a) Burial (b) Date thereof Feb 4 1941

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. H. Fife Cemetery

18. (a) Signature of funeral director P. L. Fike

(b) Address West Plains, Mo.

19. (a) 3-14 1941 (b) Mrs Pearl Cook

(Date received local registrar) (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? 850

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

28. Signature E. C. Bohrer (M. D. or other) me

Address West Plains Date signed me

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. 5,
District Number 441 5-43

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, above space should be left blank.