

No. 2  
17-39  
X214

APR 9 1941  
Registration District No. 5626

Primary Registration District No. 5626

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Washington Pa  
(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 26 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Mayview Rural (If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A? 26 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4  
year 1941 hour 12 minute 20 M.

21. I hereby certify that I attended the deceased from Jan 15, 1940, to March 4, 1941;  
that I last saw him alive on March 2, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Acute embolism delirium</u>	
Due to <u>Chronic Myocarditis</u>	<u>4 yrs</u>
Due to <u>of Bronchostasis</u>	<u>10 yrs</u>
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?  
While at work? (Specify type of place) (e) Means of injury  
23. Signature [Signature] (M. D. or other)  
Address Lexington Mo Date signed 3/4/41

8. (a) PRINT FULL NAME William D. Duesenberg  
8. (b) If veteran, name war ✓ 8. (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 Anna Duesenberg 6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased: August -5- (Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 29 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business  
12. Name Fred Duesenberg  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Sophia Bodenthal  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Duesenberg

(b) Address Mayview

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar-6-1941 (Month) (Day) (Year)

(c) Place: burial or cremation Ev. Bethel at Concordia Mo

18. (a) Signature of funeral director [Signature]  
(b) Address Concordia Mo  
19. (a) March 4-1941 (Date received local registrar) Mrs. E. M. Bodenthal (Registrar's signature)

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11-11-41

**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 *W. Roy Green*  
Licensed Embalmer No. *3079*  
P. O. Address *Wellington 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.**

Registration District No. 464

Primary Registration District No. 5626

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Madison  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Wm H. Quensing

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 \_\_\_\_\_

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

7. Birth date of deceased aug 5 1891  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 29 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4  
year 1941 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 \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature C. T. Byland (M. D. or other) \_\_\_\_\_

Address Lepington \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

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

1941  
S-11165

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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.**