

APR 9 1941

Registration District No. 490

Primary Registration District No. 3633

Registrar's No. 44

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

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 695 days  
(Specify whether years, months or days)

In this community 695 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway

(c) City or town Burlington Junction  
(If outside city or town limits, write "RURAL")

(d) Street No. 1  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Adolph Giese

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None known

4. Sex Male 5. Color or race White

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

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 41 Months 5 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

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

12. Name Unknown - Sebastian

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Ethel Jones

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

16. (a) Informant E. McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) No State San. Cem (b) Date thereof Mar 24 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation No State San. Cem

18. (a) Signature of funeral director Forsyth Funeral Home

(b) Address Mt. Vernon Mo.

19. (a) 3-24-41 (b) P. A. Holmes  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th  
year 1941 hour 1:50 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 23, 1939 to March 19th, 1941, that I last saw him alive on March 19th, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Surgical anaesthesia

Due to Laryngeal spasm

Due to Myocarditis from thyrotoxicosis and pulmonary tuberculosis.

Other conditions N.M.D.  
(Include pregnancy within 3 months of death)

Major findings: 13/12/1  
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) Anaesthesia

(b) Date of occurrence March 19, 1941

(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? 4/2/1

(Specify type of place) \_\_\_\_\_ (d) Means of injury \_\_\_\_\_

23. Signature Edwin Wilks Coroner

Address Pierce City Mo. Date signed Mar 19 1941

RECEIVED

District Health Officer No. 6,

District File Number 441-542

Date Filed APR 5 1941

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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.**

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Laurens  
 (b) City or town St. Vernon T.O.  
 (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 Adolph Giese  
 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 s

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

7. Birth date of deceased aug 10 1902  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>5</u>	<u>9</u>	..... 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) 9-24-1941 (b) P.A. Holmes  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway  
 (c) City or town Barlingtone Junction, Mo.  
 (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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 19  
 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..... and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration.....

Due to.....

Due to.....

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.

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 Edurno Wilke (M. D. or other).....

Address Pierces City Mo. Date signed.....

SUPPLEMENTARY

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

10. 1941

1941  
S-11196

**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.**