

STANDARD CERTIFICATE OF DEATH

State File No. 14325

Registration District No. 213

Primary Registration District No. 3074

Registrar's No. 143

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Jefferson City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Marys
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
(Specify whether)
 In this community 61 years
years, months or days

3. (a) PRINT FULL NAME Bernard Holtermann

3. (b) If veteran, name war _____ 3. (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 Mary Holtermann 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased March 15, 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>1</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Freeburg, Mo. (City, town, or county) (State or foreign country)10. Usual occupation Farmer.

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Holtermann
 13. Birthplace Germany (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Reinkemeyer
 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Herman Talken(b) Address Freeburg, Mo.17. (a) Burial (b) Date thereof 5-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Freeburg, Mo.18. (a) Signature of funeral director Morton Funeral Home(b) Address Box 144, Linr, Mo.19. (a) 5/2/41 (b) D. B. Spillm
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th,
 year 1941 hour _____ minute _____21. I hereby certify that I attended the deceased from April 26 ^{A.M.}
 _____, 19____, to Apr. 29 ^{P.M.}, 19____;that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death PneumoniaDue to Anemia

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)
 (b) Means of injury _____
 23. Signature Thomas J. Kelly, M.D. (M. D. or other)
 Address _____ Date signed _____

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DM ANSWER

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 Vernon M. Morton
Licensed Embalmer No 4125
P. O. Address Linn

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.

NO. 38
41
1-27852
COPY

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(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 Bernard Holtermann
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month apr day 29 year 1941 hour _____ minute _____ M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death Pneumonia Duration _____
Robar.

8. AGE: Years 61 Months 1 Days 14 If less than one day _____ hr _____ min.

Due to Anemia
Due to _____

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

Other conditions _____ (include pregnancy within 3 months of death) 174

10. Usual occupation _____

Major findings: _____

11. Industry or business _____

Of operations _____

12. Name _____

Of autopsy _____

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

14. Maiden name _____ (State or foreign country)

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)

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 _____ Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-14325