

MAY 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14972

Registration District No. 454

Primary Registration District No. 56-20-A-4218 Registrar's No. 857

1. PLACE OF DEATH

(a) County LAFAYETTE
(b) City or town ALMA MISSOURI
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(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 days8. (a) PRINT FULL NAME PAULA ELISE ANNA DIECKHOFF8. (b) If veteran, name war _____ ✓
8. (c) Social Security No. _____ ✓4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife ALVIN DIECKHOFF 6. (c) Age of husband or wife if alive 42 years7. Birth date of deceased JUNE 3 1898
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
42 10 13 hr. min.9. Birthplace ALMA MO
(City, town, or county) (State or foreign country)10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name JULIUS HENRY LEO FRERKING13. Birthplace CONCORDIA MO
(City, town, or county) (State or foreign country)14. Maiden name CAROLINE BRACKMANN15. Birthplace CONCORDIA MO
(City, town, or county) (State or foreign country)16. (a) Informant ALVIN DIECKHOFF(b) Address ALMA MO17. (a) BURIAL (b) Date thereof APRIL 19 1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation LUTHERAN CEMETERY18. (a) Signature of funeral director E. S. JAMES(b) Address CONCORDIA MO19. (a) April 18 (b) ms Frank McClure
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE MO(c) City or town ALMA MO
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 16
year 1941 hour 10 minute 35 A.M.21. I hereby certify that I attended the deceased from 9-1-38
_____ 1941 to 4-16 1941;that I last saw her alive on 4-16 1941
and that death occurred on the date and hour stated above.Immediate cause of death uremiaDue to anuria

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? 7
(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 Paul Lowell (M. D. or other) 0Address Blackburn, Mo. Date signed 4-17-41

Duration

weekweek

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

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

1232

RECEIVED
District Health Officer No. 8,
District File Number
5-9-44
Date Filed

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 me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed E. S. Jamies
Licensed Embalmer No. 2058
P. O. Address Concordia 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. 14972

Registration District No. 454

Primary Registration District No. 4268

Registrar's No. 8

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

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Alma
(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 Paula Elise Anna Deckhoff
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 42 Months 10 Days 13
If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 16
 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: uremia
 Due to anuria
 Due to chronic nephritis
 Other conditions _____
(Include pregnancy within 3 months of death) 1218

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?

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

23. Signature Paul Lovell MD (M. D. or other) _____
 Address Blackburn Mo Date signed 6-20-41

SUPPLEMENTAL

