FILED JUN 19 1941

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

17558
Do not use this space.

1. PLACE OF DEATH
(a) County: Clark — Registration District No.: 192
(b) Township: Grant Home — Primary Registration District No.: 412 — Registered No.: 23
(c) City: Revere — (d) Street No.: 1 — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred: yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Essie Elnora Kautz
(a) Residence, No.: Revere Mo — St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~Married, Widowed, or Divorced~~: Widow
5A. ~~Married~~, Widowed, ~~or Divorced~~ (OR) WIFE OF: Geo W. Kautz
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct 6 - 1880
7. AGE: Years 60 — Months 7 — Days 13 — If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: None
9. Industry or business in which work was done, as saw mill, bank, etc.: None
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Clark Co Mo

FATHER
13. NAME: John H. Langley
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

MOTHER
15. MAIDEN NAME: Hannah Dowlar
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

17. INFORMANT (ADDRESS):
18. BURIAL, ~~CREMATION, REMOVAL~~ PLACE: Revere Mo DATE: May 20 1941
19. FUNERAL DIRECTOR (ADDRESS): G. H. Epperhart Revere Mo
20. FILED May 19 1941 J. L. McConnell Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 19 1941
22. I HEREBY CERTIFY, That I attended deceased from May 16 1941 to May 19 1941
I last saw her alive on May 18 1941. Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Cancer of Bladder | |
| 52 yr | |
| Other contributory causes of importance: Diabetes Mellitus | 6 yr |

Name of operation: None — Date of:
What test confirmed diagnosis? None — Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury: , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury:
Nature of injury:

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify:
(Signed) J. L. McConnell M. D.
(Address) Revere Mo

(Licensed Embalmer's Statement on Reverse Side)

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

**STATEMENT BY LICENSED EMBALMER**

I, G. W. Epperhart, Licensed Embalmer No. 1802

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed G. W. Epperhart

Licensed Embalmer No. 1802

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

. No. 2B
—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 17538

Registration District No. 192 Primary Registration District No. 4115 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Clark

(b) City or town Revere
(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 years, months or days)
In this community

**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 Essie Elnora Kautz

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 wd

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)

8. AGE: Years 60 Months 7 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

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Harry Goldsberry
(b) Address Ethel, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) May 20 194 (Date received by local registrar) (b) J. L. McConnell (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 19 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. L. McConnell (M. D. or other)
Address Revere Date signed

SUPPLEMENTARY