

Registration District No. 19 Primary Registration District No. 5026 Registrar's No. _____

1. PLACE OF DEATH: **DECEASED JUL 23 1941**
 (a) County Atchison
 (b) City or town Rural - Rock township
 (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 _____
 In this community 88 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Atchison
 (c) City or town Rock Port MO - Rural
 (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.

3. (a) PRINT FULL NAME Anna Mary Ensminger
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 10 year 1941 hour 7:30 minute A. M.
 21. I hereby certify that I attended the deceased from July 1, 1941, to July 10, 1941;
 that I last saw her alive on July 4 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife A. T. Ensminger
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 20 1852
 (Month) (Day) (Year)

Immediate cause of death Senile decay - old age! Duration about 2 yrs -
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) 162 lb

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>7</u>	<u>20</u>	hr. min.

9. Birthplace Atchison County MO
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____
 MOTHER FATHER
 12. Name Geo. John Wolff
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Anna K. Branstetter
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically
 Major findings: Of operations _____
 Of autopsy _____

16. (a) Informant's own signature M. L. Shepperdson
 (b) Address Rock Port
 17. (a) Rural (b) Date thereof July 12, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Orange Hill Cemetery
 18. (a) Signature of funeral director E. E. Salitton
 (b) Address Rock Port, MO
 19. (a) 7-10-1941 (b) Mary B. Chamberlain
 (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 James A. Gray (M. D. or other) _____
 Address Watson - MO - Date signed 7-10-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

C. C. Clifton Registered Apprentice No.
 working under my personal supervision.

Signed C. C. Clifton

Licensed Embalmer No. 3707

P. O. Address Rock Hill, Md.

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. 19

Primary Registration District No. 30 26

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Atchison

(b) City or town Polk Twp
(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 Anna Mary Ensminger

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 Widowed

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 10
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.

Immediate cause of death _____

8. AGE: Years 88 Months 7 Days 20
If less than one day _____ min.

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

10. Usual occupation _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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) 7-10 (b) Mary G. Chamberlain
(Date received local registrar) (Registrar's signature)

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) _____ Means of injury _____

23. Signature James A. Gray (M. D. or other) _____
Address Watson Mo Date signed _____

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

SUPPLEMENTAL

