

FILED JUL 15 1941

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

22143
Do not use this space.

AGE OF DEATH

(a) County Marion Registration District No. 541
(b) Township Jefferson Primary Registration District No. 5737 Registered No. _____
(c) City _____ (d) Street No. _____
(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 Mrs. Minnie Hafner
(a) Residence, No. _____ 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. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Otto Hafner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 31, 1877.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 2 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Bem Mo.

13. NAME Hermann Enke

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME --- Homfeldt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT W. R. Hafner (ADDRESS) Summerfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Schanning Cem DATE Apr. 12, 1941

19. FUNERAL DIRECTOR S. G. Licklider (ADDRESS) Belle, Mo.

20. FILED July 10, 1941 Special Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 9, 1941.

22. I HEREBY CERTIFY, That I attended deceased from hosp. - 15-16-1940 to Apr. 9, 1941
I last saw her alive on Apr. 9, 1941 Death is said to have occurred on the date stated above, at 1 p. m.
The principal cause of death and related causes of importance were as follows:

Cancer of the Peritoneum

Date of onset March 1940

Other contributory causes of importance: 40 m

Name of operation none Date of _____
What test confirmed diagnosis? Symptom Was there an autopsy? no

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) W. R. Hafner M. D.
(Address) Belle, Mo.

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, _____, Licensed Embalmer No. _____

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

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

_____ Licensed Embalmer No. _____

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 541

Primary Registration District No. 5737

Registrar's No. _____

1. PLACE OF DEATH:

(a) County maries
(b) City or town _____
(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 Mo (b) County maries
(c) City or town Summerfield, 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 _____

3. (a) PRINT FULL NAME Minnie Hafner
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. MEDICAL CERTIFICATION
20. DATE OF DEATH Month Apr. day 9
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 31 1874
(Month) (Day) (Year)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____ (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) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) Aug 20 - 4 p.m. James J. Jones
(Date received local registrar) (Registrar's signature)

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

