DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

24758

State File No.

Registration District No. 116

Primary Registration District No. 5174 B

Registrar's No. 8

1. PLACE OF DEATH:

(a) County: CAPE GIRARDEAU

(b) City or town: RURAL (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: 66 years

2. USUAL RESIDENCE OF DEACESED:

(a) State: MISSOURI (b) County: CAPE-GIRARDEAU

(c) City or town: 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.? 0 years.

3. (a) PRINT FULL NAME: ANNA-LOUISE-FUHRMANN

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: MARRIED

6. (b) Name of husband or wife: J.A. FUHRMANN

6. (c) Age of husband or wife if alive: 68 years

7. Birth date of deceased: Jan (Month) 18 (Day) 1875 (Year)

8. AGE: Years 66 Months 6 Days 14 If less than one day hr. min.

9. Birthplace: CAPE GIRARDEAU (City, town, or county) U (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: CHARLES-NEUMEYER

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

MOTHER 14. Maiden name: CAROLINE BAERECKE

15. Birthplace: CAPE GIRARDEAU (City, town, or county) U (State or foreign country)

16. (a) Informant's own signature: J.A. Fuhrmann

(b) Address: Goldonville Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof: July 4 1941 (Month) (Day) (Year)

(c) Place: burial or cremation: Zion M.E. Cem.

18. (a) Signature of funeral director: Wilson-Stotler-Seabaugh

(b) Address: Jackson Mo

19. (a) July 3-1941 (Date received local registrar) (b) Mrs. N. W. Ford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 2 year 1941 hour 10 minute M.

21. I hereby certify that I attended the deceased from 5-18, 1941, to 7-2, 1941; that I last saw her alive on 7-1-, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(1) Cor Myocarditis	
(2) Acute Nephritis	
Due to: Chronic Cardiovascular renal disease	
Due to: Causing uremia	
Other conditions (Include pregnancy within 3 months of death): Marked Hypertension	

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? ✓ (Specify type of place) (e) Means of injury: ✓

23. Signature: [illegible] (M. D. or other)

Address: Jackson Mo Date signed 7-3-41.

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39
1 X19311

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

V. S. No. 2B
0M—8-21-41
I X29288

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. 24758

Registration District No. 126 Primary Registration District No. 5174 B Registrar's No. 8

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(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 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: Anna L. Fuhrmann
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: years
7. Birth date of deceased: (Month) (Day) (Year)

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:
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) Burial (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) July 4, 1941 (Date received local registrar) (b) Mrs M. M. Ford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July Day: 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	Duration
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)
(b) 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: (M. D. or other)
Address: Date signed:

SUPPLEMENTARY