No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 25 1941

ation District No. 294

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25030

Primary Registration District No. 54093

Registrar's No.

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

1. PLACE OF DEATH:
(a) County FRANKLIN
(b) City or town (Leslie 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 1 (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town Leslie
(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.

036 00

3. (a) PRINT FULL NAME ANNA FREVERT ERNST

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife DAVID ERNST

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

7. Birth date of deceased JAN. (Month) 9 (Day) 1869 (Year)

8. AGE: Years 72 Months 6 Days 25 If less than one day hr. min.

9. Birthplace SMITH CREEK, (City, town, or county) MO. (State or foreign country) 0

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name CONRAD FREVERT
13. Birthplace GERMANY (City, town, or county) (State or foreign country) 4

MOTHER
14. Maiden name KOELLING
15. Birthplace GERMANY (City, town, or county) (State or foreign country) 4

16. (a) Informant ✓
(b) Address

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-5-41 (Month) (Day) (Year)
(c) Place: burial or cremation NEW HAVEN MO.

18. (a) Signature of funeral director C. Duty & Son
(b) Address New Haven, Mo.

19. (a) Aug. 9, 1941 (Date received local registrar) (b) M. H. Duckworth (Registrar's signature)
267

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8/3 day year 1941 hour 12 minute 40 P. M.

21. I hereby certify that I attended the deceased from June, 1940 to 8-3-, 1941 that I last saw her alive on 8-3-, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Cerebral Hemorrhage — 2 days
Due to
Due to 238
Other conditions Embolism of Femoral Vein
(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 W. H. Humphrey (M. D. or other) D
Address Fr. Mo. Date signed 8/4/41

(Licensed Embalmer's Statement on Reverse Side)

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 Earl Fertig

Licensed Embalmer No. 338

P. O. Address Yeulbavin M

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

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
M—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. 25030

Registration District No. 294 Primary Registration District No. 5409B Registrar's No.

1. PLACE OF DEATH
(a) County Franklin
(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 F. Ernst
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 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 Mrs. Paul Knollenberg
(b) Address St. Clair, 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) Aug. 4, 1941 (Date received local registrar) (b) N. M. Duckworth (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 2 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 — 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?
While at work? (Specify type of place) (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-25030