

UG 15 1941

Registration District No. 374

Primary Registration District No. 4338

Registrar's No.

1. PLACE OF DEATH:

(a) County Moniteau
 (b) City or town Jamestown
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 (Specify whether
 In this community 60 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Moniteau
 (c) City or town Jamestown Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? Yes (Yes or No)
 If yes, name country U.S.A.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 25
 year 1941 hour 7:30 minute 30 A.M.
 21. I hereby certify that I attended the deceased from March
1941 to 7/25/41 1941
 that I last saw him or her alive on 7/24/41 1941
 and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Margdoline Lehman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased April 18 1864
 (Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Canton Berg 5 Switzerland
 (City, town, or county) (State or foreign country)

10. Usual occupation House keeper

MOTHER FATHER 11. Industry or business _____

12. Name John Grossplauer
 13. Birthplace Canton Berg 5
 (City, town, or county) (State or foreign country)
 14. Maiden name Margdoline
 15. Birthplace Canton 5
 (City, town, or county) (State or foreign country)

16. (a) Informant Gottfried Lehman

(b) Address Ma. Church
 17. (a) Ma. Church (b) Date thereof July 27 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____
 18. (a) Signature of funeral director Chas Fullrich
 (b) Address Jamestown Mo

19. (a) July 25 1941 (b) Abbie Biesel
 (Date received local registrar) (Registrar's signature)

Immediate cause of death Metrol Regurgitation Duration unknown
 Due to _____
 Due to 72B
 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? Jamestown Mo.
 (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) (e) Means of injury _____
 23. Signature B. R. Reynolds (M.D. or other) 200
 Address Jamestown Mo. Date signed 7/25/41

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

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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 25659

Registration District No. 374

Primary Registration District No. 4338

Registrar's No.

1. PLACE OF DEATH:

(a) County Monteau
(b) City or town Jamestown
(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 Magdaline Lehman

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.....

6. (b) Name of husband or wife Godfried 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 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 (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address Jamestown Mo.

17. (b) (a) Sept-18-1941 (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Sept-18-1941 (b) Grace Gutzwiller

(c) (If received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 21 Year 1941 Hour 10 Minute 15 M.

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

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

