

FILLED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31232

Registration District No. 128

Primary Registration District No. 5176B-

Registrar's No.

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Small
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson mo R#4
(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, month or days
3. (a) PRINT FULL NAME Josephine Isabelle Ludwig
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 71 5. Color or race w. 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Chas Ludwig 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Nov 2 1876 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>8</u>	<u>27</u>	hr. min.

9. Birthplace Amberg MO (City, town, or county) (State or foreign country)
10. Usual occupation House wife

11. Industry or business _____
MOTHER FATHER { 12. Name Jacob Klambach
13. Birthplace Amberg MO (City, town, or county) (State or foreign country)
14. Maiden name Mary Richter
15. Birthplace Amberg MO (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas Ludwig
(b) Address Jackson mo R#4
17. (a) Burial (b) Date thereof 9/27/41 (Month) (Day) (Year)
(c) Place: burial or cremation St John's Cemetery
18. (a) Signature of funeral director McComb
(b) Address Jackson mo
19. (a) 9/27/1941 (Date received local registrar) (b) Law O Krepe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Girardeau
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Jackson mo R#4 (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 27 year 1941 hour 5:1 minute AM

21. I hereby certify that I attended the deceased from 4-15, 1940 to 9-26, 1941; that I last saw her alive on 9-26-41, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death
Due to Acute passive congestion of lung
Due to Obstr. myocarditis
Other conditions Uninsured
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 938

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 Arthur Eater (M. D. or other)
Address Jackson mo Date signed 9/27/41

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Thos. T. Allen*

Licensed Embalmer No. *4055*

P. O. Address..... *Jackson*

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

If this body is not embalmed, above space should be left blank.

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STANDARD CERTIFICATE OF DEATHState File No. 21232Registration District No. 128Primary Registration District No. 5176B

Registrar's No. _____

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 whetherIn this community _____
years, months or days)3. (a) PRINT
FULL NAME Josephine D Ludwig3. (b) If veteran
name war _____3. (c) Social Security
No. _____4. Sex F5. Color or
race W6. (a) Single, widowed, married
divorced married

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased Nov 2 1876

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

648174

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)

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) _____

(b) _____

(Date received local registrar)

(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him/her 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 sta-
tistically.

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

MOTHER FATHER

S-31232 1941