

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

FILLED OCT 21 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32850

Registration District No. 884

Primary Registration District No. 6126

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Marthasville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ev. Emmanuel Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 years
In this community 11 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Warren
(c) City or town Marthasville MO
(If outside city or town limits, write "RURAL")
(d) Street No. Emmanuel Home
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6
year 1941 hour 2 minute 30 P.
21. I hereby certify that I attended the deceased from Sept 1
1941 to Sept 6 1941
that I last saw her alive on Sept 5 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial condition Duration 3 yr
Due to General aneurysm
flexible or depressed for
Due to birth 1940

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 93%
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 _____ (d) Means of injury _____
23. Signature T. C. Johnson (M. D. or other) _____
Address Marthasville MO Date signed 9/7/41

3. (a) PRINT FULL NAME HULDA A. MEYER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race WH 6. (a) Single, widowed, married, divorced SI
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Aug 23 1888
(Month) (Day) (Year)

8. AGE: Years 53 Months _____ Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Huntingburg, Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Mother

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

14. Maiden name Mother

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

16. (a) Informant: John G. Stuhl

(b) Address Marthasville, Mo.

17. (a) Burial (b) Date thereof 9/10/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntingburg Ind.

18. (a) Signature of funeral director Fred W. Schuster

(b) Address Marthasville Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

(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 *Fred. W. Lichtenberg*

Licensed Embalmer No. *1321*

P. O. Address *Martha'sville Va*

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. 32850

Registration District No. 884

Primary Registration District No. e 176

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Marthasville
(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 Hulda A. Meyer

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 S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Aug 23, 1888
(Month) (Day) (Year)

8. AGE: Years 53 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 _____

15. Birthplace _____ (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) Sept 7/41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ 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)

(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 _____

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SUPPLEMENTARY

1941

S-32850