

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

FILED JAN 20 1942

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

42456

1. PLACE OF DEATH

County Maries Registration District No. 041  
Township Jefferson Primary Registration District No. 03-11  
City Belle (No. 1) St.          Ward         

2. FULL NAME Laura L. Gehlert

(a) Residence, No.          St.          Ward.           
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John F. Gehlert  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 24, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 2 23

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas County Mo.

13. NAME Wm. Mitchem

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois.

15. MAIDEN NAME Susanne Atkins

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maries County Mo.

17. INFORMANT (ADDRESS) Herman Gehlert Belle, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Cem. DATE Nov. 19, 1941

19. UNDERTAKER (ADDRESS) S. G. Lickliger Belle, Mo.

20. FILED Jan 10 1942 [Signature] Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 17, 1941

22. I HEREBY CERTIFY, That I attended deceased from 7/20, 1941, to 11/17, 1941.  
I last saw h. ex alive on 11/17, 1941. Death is said to have occurred on the date stated above, at 11 a.m.  
The principal cause of death and related causes of importance were as follows:

Myocardial Degeneration Date of onset 1940

Other contributory causes of importance:  
Arteriosclerosis 1930  
Cerebral Hemorrhage 1938

Name of operation          Date of           
What test confirmed diagnosis?          Was there an autopsy?         

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?          Date of injury         , 19          
Where did injury occur?          (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury           
Nature of injury         

24. Was disease or injury in any way related to occupation of deceased?           
If so, specify           
(Signed) Dr. R. H. Schouhal  
(Address) Belle, Mo.

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.



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42456

Registration District No. 541

Primary Registration District No. 4321

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Maries  
(b) City or town Belle  
(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 Missouri (b) County Maries  
(c) City or town Belle  
(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 Laura L. Gehlert  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov Day \_\_\_\_\_ 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 \_\_\_\_\_

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 Aug 24 1866  
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 23 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) 1/31/42 (b) Erma Bassett  
(Date received local registrar) (Registrar's signature)

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.

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

SUPPLEMENTARY

