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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. 2775

FILED FEB 12 1942

Registration District No. 514 Primary Registration District No. 5683 Registrar's No.

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Ludlow (rural) Monroe 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 (Specify whether
In this community 20 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 59

(a) State Missouri (b) County Livingston

(c) City or town Ludlow (rural)
(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.

3. (a) PRINT FULL NAME Alfa Kromeich

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 Charlie Kromeich

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June (Month) 24 (Day) 1888 (Year)

8. AGE: Years 53 Months 7 Days 7 If less than one day hr. min.

9. Birthplace Dawn (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Monroe Decker
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Lizzie Berry
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Charlie Kromeich
(b) Address Ludlow, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-42 (Month) (Day) (Year)
(c) Place: burial or cremation Monroe Cem.

18. (a) Signature of funeral director Bernard F. Mead
(b) Address Braymer, Missouri.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2/1 day 1
year 42 hour 8 minute - P. M.

21. I hereby certify that I attended the deceased from 2-1 to 2/1
, 1942 to , 1942
that I last saw her alive on 2-1, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Bronchial) following Flue

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 330

Of autopsy

Duration

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 0

23. Signature Geo. Moss (M. D. ~~another~~)
Address Ludlow, Mo Date signed 2-3-42

(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 Bernard F. Mead

Licensed Embalmer No. 2801

P. O. Address Braymer, Mo.

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.

V. S. No. 2B
M—8-21-41
I X29288

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2775

Registration District No. 514 Primary Registration District No. 5683 Registrar's No.

1. PLACE OF DEATH:
(a) County: Livingston
(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 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: Alfa Kromeich
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: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: June (Month) 24 (Day) 1888 (Year)

8. AGE: Years 53 Months 7 Days 7 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
(b) Address
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) Feb 3, 1942 (Date received local registrar) (b) Hannah Copple (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY