No. 2
-1-4-41
5-17-

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 23 1942

Registration District No. 608

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 14855

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1227 Jackson St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XXXX (Specify whether years, months or days)

In this community 4 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Linn

(c) City or town Cedar Rapids
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country XXX

3. (a) PRINT FULL NAME Johannah C. Gensicke

3. (b) If veteran, name war XXXX

3. (c) Social Security No. XXXX

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Fredrick H. Gensicke

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

7. Birth date of deceased July (Month) 11 (Day) 1865 (Year)

8. AGE: Years	Months	Days	If less than one day
76	8	28	XX hr. XX min.

9. Birthplace Milwauke (City, town, or county) Wisconson (State or foreign country)

10. Usual occupation At home

11. Industry or business XXX

FATHER
12. Name Unknown
13. Birthplace XX (City, town, or county) Germany (State or foreign country)

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

16. (a) Informant Frank C. Lang
(b) Address Chillicothe, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/11/42 (Month) (Day) (Year)
(c) Place: burial or cremation Cedar Rapids, Iowa

18. (a) Signature of funeral director James D. Gordon
(b) Address Chillicothe, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9 year 1942 hour 4 minute 25 P.M.

21. I hereby certify that I attended the deceased from Dec 23 1941 to April 9 1942 that I last saw h. alive on April 8 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis — Duration 5 years

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 C. Collier (M. D. or other)
Address Chillicothe Mo Date signed 4/10/42

458

(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 James D Gordon

Licensed Embalmer No. 1870

P. O. Address Belleville Ont

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.

. S. No. 2B
0M—8-21-41
I X29288

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. 14855-

Registration District No. 308 Primary Registration District No. 3026 Registrar's No.

1. PLACE OF DEATH
(a) County Livingston
(b) City or town Chillicothe
(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 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County Linn
(c) City or town Cedar Rapids
(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 Johannah C. Gensicke
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 17 (Day) 1865 (Year)
8. AGE: Years 76 Months 8 Days 28 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) April-10 (Date received local registrar) (b) Lou Ella Curry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 9 year 1942 hour 4 minute 15 P. 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.
Immediate cause of death Chronic Interstitial Nephritis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY