

FILED JUL 28 1942

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

24626

Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette Registration District No. 457
(b) Township Freedom Primary Registration District No. 4271 Registered No. 7
(c) City Concordia Mo. (d) Street No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Concordia Mo. Lafayette Co. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Fritz Brunkhoff</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 27-1863</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>11</u>
	DAYS <u>27</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>housewife</u>	
	9. Industry or business in which work was done, as 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) <u>Concordia, Missour</u>		
FATHER	13. NAME <u>unknown Bartels</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
MOTHER	15. MAIDEN NAME <u>Dorothy Schernhouse</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
17. INFORMANT (ADDRESS) <u>Mrs. F. Schawengerdt</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Lutheran cemetery</u> DATE <u>June 23</u> 19 <u>42</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Madame Ewing</u> <u>Socialia</u>		
20. FILED <u>June 22-42</u> <u>Mrs. Walter Walkenhorst</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>June 21</u> 19 <u>42</u>	Date of onset
22. I HEREBY CERTIFY, That I attended deceased from <u>June 4</u> 19 <u>42</u> to <u>June 14</u> 19 <u>42</u> Last saw her alive on <u>June 13</u> 19 <u>42</u> Death is said to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows: <u>Bright Disease</u>	
Other contributory causes of importance: <u>asthma bronchial</u>	
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 <u>Periment Shuman</u> , M. D. (Signed) <u>Concordia Mo</u> (Address)	

(Licensed Embalmer's Statement on Reverse Side)

PRINTED WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

No. 8,

Date Filed 7-27-42

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 Duane Ewing

Licensed Embalmer No. 3847

P. O. Address Sidalia, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24624
Registrar's No. 7

Registration District No. 457 Primary Registration District No. 4271

1. PLACE OF DEATH:

(a) County Safayette
(b) City or town Fredman
(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)

3. (a) PRINT FULL NAME Fritz Brenkheff
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 June 24 1881
(Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 27 If less than one day 14 min.

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

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)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a)..... (b)..... (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..... day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Bright Anger acute

Due to.....
Due to.....

Other conditions asthma bronchial
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... 130
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. Sign Ferdinand Shryman (M. D. or other MD)
Address Memoria Mo Date signed 8-29-41

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

SUPPLEMENTARY

