

No. 2  
9-4-4  
5-17-3  
I X2

FILED SEP 1 1942  
Registration District No. 1300

Primary Registration District No. 5113

Registrar's No. 12

1. PLACE OF DEATH:  
(a) County Bollinger Co.  
(b) City or town Patton, Mo.  
(c) Name of hospital or institution: Union Sup  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 37 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Bollinger  
(c) City or town Patton, Mo.  
(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 Amie F Adler  
3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 17 year 1942 hour 11 minute 55 M.  
21. I hereby certify that I attended the deceased from Aug 13<sup>th</sup> 1942 to Aug 17<sup>th</sup> 1942  
that I last saw h. alive on Aug 17<sup>th</sup> 1942 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow  
7. (b) Name of husband or wife Jacob F Adler (c) Age of husband or wife if alive 28 years  
7. Birth date of deceased Aug 28 1865 (Month) (Day) (Year)

Immediate cause of death Pneumonia  
Bronchial Pneumonia 12 hrs -  
Due to debility  
Due to ulcerated rt. leg & toxemia therefrom  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 76 Months 11 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Peter Hartle

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

14. Maiden name Bollinger

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

16. (a) Informant Bertha Leonard

(b) Address 2146 Washington St, Patton, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof Aug 17 1942 (Month) (Day) (Year)

(c) Place: burial or cremation Jones Cemetery

18. (a) Signature of funeral director Ed H. Webb

(b) Address Patton, Mo.

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
107

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 Peter nurse (M. D. or other) \_\_\_\_\_  
Address Patton, Mo. Date signed 8/17/42

1062 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**RECEIVED**

District Health Officer No. 4  
District file Number 942-1141  
Date filed 9-8-42

**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 John O. Helt  
Licensed Embalmer No. 4264  
P. O. Address Fredericktown

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26651

Registration District No. 32

Primary Registration District No. 5113

Registrar's No. 12

1. PLACE OF DEATH

(a) County Bellinger Co

(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 \_\_\_\_\_)  
In this community 57 yrs.  
years, months or days

3. (a) PRINT FULL NAME Anna J Adler

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 aug 28  
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Mo  
(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) 8/17/42 (b) Mrs. Hester Graham  
(Date received local registrar) (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 Aug Day 28 Year \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

