11-10-39
17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1942

Registration District No. 39

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4097

30052
State File No.
Registrar's No. 136

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Harrisonville
(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 2 years.
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cass 19
(c) City or town: Harrisonville 8
(If outside city or town limits, write "RURAL") 0
(d) Street No. ____
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ____ years.

8. (a) PRINT FULL NAME: HANNAH RIEMERS GARNER

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: George R Garner
6. (c) Age of husband or wife if alive: 74 years
7. Birth date of deceased: Jan (Month) 19 (Day) 1868 (Year)

8. AGE: Years 74 | Months 8 | Days 12 | If less than one day ____ hr. ____ min. 0

9. Birthplace: ~~Dunnigan~~ St Louis Mo (City, town, or county) ~~Iowa~~ (State or foreign country)
10. Usual occupation: House-wife
11. Industry or business: ____
FATHER
12. Name: August Ernst Riemers
13. Birthplace: ____ (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name: ____
15. Birthplace: ____ (City, town, or county) ____ (State or foreign country)
16. (a) Informant: Mrs Dwight E Adams
(b) Address: 7238 Jaybee K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-3-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Peculiar Cemetery
18. (a) Signature of funeral director: RUNNENBURGER'S
(b) Address: HARRISONVILLE, MO.
19. (a) Oct. 3/42 (Date received local registrar) (b) Margaret Volle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1st year 1942 hour 8:00 minute P M.

21. I hereby certify that I attended the deceased from Apr 4 1942 to Oct 1 1942; that I last saw him alive on Oct 1 1942; and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral Regurgitation and Arterial Hypertension — Duration
Due to: General Cardiac Collapse
Due to: Pulmonary Oedema
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: David D Lang (M. D. or other)
Address: Harrisonville Mo Date signed 10/3

(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 Ernest Rumenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.

. S. No. 2B
OM—8-21-41
X25238

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30052

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 136

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Harrisonville
(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 (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 Hannah R Gardner

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 Jan 19 1868 (Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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 Christina Hamm
15. Birthplace Either St. Louis or Germany (City, town, or county) (State or foreign country)

16. (a) Informant Not sure, all she was able to find
(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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19 ;
that I last saw h 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)
(b) 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