S. No. 2
—1-4-41
5-17-39
X26390

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

1786

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 21 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 49 | Primary Registration District No. 5174 | Registrar's No. 21

1. PLACE OF DEATH:
(a) County: Camden
(b) City or town: rural - Adair township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Climax Springs /
(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: years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Camden
(c) City or town: rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Climax Springs
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Franklin Tresenriter
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male 0
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Annie Tresenriter
6. (c) Age of husband or wife if alive: 62 years
7. Birth date of deceased: June (Month) 11 (Day) 1862 (Year)
8. AGE: Years 80 | Months 5 | Days 29 | If less than one day hr. min.
9. Birthplace: Near Columbus, (City, town, or county) Indiana / (State or foreign country)
10. Usual occupation: farmer
11. Industry or business: own farm
FATHER 12. Name: Henry Tresenriter
FATHER 13. Birthplace: Near Cincinnati, Ohio, in (City, town, or county) Indiana / (State or foreign country)
MOTHER 14. Maiden name: Elizabeth Mc Queen
MOTHER 15. Birthplace: central part of (City, town, or county) Indiana / (State or foreign country)
16. (a) Informant: Thomas Lee Tresenriter
(b) Address: Climax Springs, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 13 42 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Cem.
18. (a) Signature of funeral director: Benjamin Woolard
(b) Address: Camdenton
19. (a) 12-42 (Date received local registrar) (b) Mrs. G. R. Jackson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10th year 1942 hour 12.00 minute 00 A.M.
21. I hereby certify that I attended the deceased from July 1941, to Dec. 10th 1942; that I last saw him alive on Dec 10th 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Terminal Pneumonia	5 days
Due to: General Debility	2 1/4 yrs.
Due to: Stroke	
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: Robert L. Horton (M. D. or other) D.O.
Address: Climax Springs, Mo. Date signed 12-10-42

12-12-42 10.00 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 12-42-1401
Date Filed 1-12-43

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 Abbie Bankson Woole

Licensed Embalmer No. 2488

P. O. Address Cambridge, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

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State File No. 1786

Registration District No. 49 Primary Registration District No. 5174 Registrar's No. 21

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

1. PLACE OF DEATH:
(a) County: Camden
(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: Franklin Tresenreiter
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
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) 11 (Day) 1862 (Year)

8. AGE: Years 80 Months 5 Days 29 If less than one day hr. min.

9. Birthplace: (City, town, or county) Ind. (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) 3-2-43 (Date received local registrar) (b) Mrs. G. R. Jackson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 10 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

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(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