2154

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 116020 Primary Registration District No. 30206 Registrar's No. 10

6-17-39
X26390

36
62
2

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

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)
In this community 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin 36
(c) City or town Washington Mo. (If outside city or town limits, write "RURAL") 2
(d) Street No. 702 W 5th St. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes name country 0

3. (a) PRINT FULL NAME KATHRINA HOELSCHER
3. (b) If veteran, name war no.
3. (c) Social Security No. none
4. Sex Female
5. Color or race W.
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Herman Hoelscher
6. (c) Age of husband or wife if alive none years
7. Birth date of deceased May (Month) 23 (Day) 1845 (Year)
8. AGE: Years 97 Months 8 Days 3. If less than one day hr. min.
9. Birthplace Germany (City, town, or county) 4 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business —
12. FATHER Name Henry Helling
13. FATHER Birthplace Germany (City, town, or county) 4 (State or foreign country)
14. MOTHER Maiden name Bickmann
15. MOTHER Birthplace Germany (City, town, or county) 4 (State or foreign country)
16. (a) Informant Mrs. Josephine Greve
(b) Address Washington Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-43 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Mo
18. (a) Signature of funeral director Otto A. Oo
(b) Address Washington Mo.
19. (a) Jan 27-43 (Date received local registrar) (b) Lucile Ruether (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 year 1943 hour 6:45 minute A M.
21. I hereby certify that I attended the deceased from 1936 19 to Jan 26 1943 that I last saw her alive on Jan 26, 1943 19 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chr. Myocarditis	
Bronchopneumonia	
Due to Fractured hip	
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: 93 V
(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 V
23. Signature J. T. Poos (M. D. or other) MD
Address Washington, Mo. Date signed 1/27/43

1181

(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. none

working under my personal supervision.

Signed Henry W. Otto

Licensed Embalmer No. 3560

P. O. Address Washington

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
M—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. 2154

Registration District No. 116 | Primary Registration District No. 3020 | Registrar's No. 12

1. PLACE OF DEATH:

(a) County: Franklin

(b) City or town: Washington
(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: Katherina Holscher

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: May (Month) 23 (Day) 1851 (Year)

8. AGE: Years 97 | Months 8 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Germany (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. Day 16 year 1943 hour minute 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: Chr. Myocarditis (Duration)
Bronchopneumonia

Due to: Fracture Hip

Due to: Fall

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): Accident

(b) Date of occurrence: Jan. 14, 1943

(c) Where did injury occur? Home (City or town) Washington (County) Franklin (State) Mo

(b) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? Walking around (c) Means of injury: Fall

23. Signature: E. R. Fox M.D. (M. D. or other)

Address: Washington Mo. Date signed: 1/2

SUPPLEMENTARY