

No. 2
- 442
- 17

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11292

State File No.

Registrar's No. 60

DECEASED APR 7 1943

Registration District No. 16

Primary Registration District No. 3061

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Flat River
(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 Marie E. Herman

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased March 27, 1921
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

21 11 15 hr. min.

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

10. Usual occupation Factory work

11. Industry or business John W. Hermann

12. Name John W. Hermann

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

14. Maiden name Clara Mueller

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

16. (a) Informant John W. Hermann

(b) Address Lawrenceton

17. (a) Burial (b) Date thereof 3 17 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrenceton

18. (a) Signature of funeral director Caldwell Bros.

(b) Address Flat River

19. (a) Mar 19, 1943 (b) Byndie Buhmester
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois

(c) City or town Farmington
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country..... Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14
year 1943 hour 11 minute A. 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.

Immediate cause of death.....
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

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 O.P.

(b) Date of occurrence March 14, 1943

(c) Where did injury occur Flat River, St. Francois, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public highway construction
While at work?..... (Specify type of place) (c) Means of injury..... car accident

23. Signature Robert M. Shath (M.D. or other)
Address Farmington, Mo. Date signed 3/15/43

RECORDED

District Health Officer No. 4
District File Number 443-1968
Date Filed 4-5-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 11292
Registrar's No. 60

Registration District No. 316 Primary Registration District No. 3061

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town St. Robert
(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 Mae E. Herman
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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 27
(Month) (Day) (Year)

8. AGE: Years 21 Months 11 Days 2 If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) 3-19-1943 (b) Byndie Toluhmester
(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 March Day 14 Year 1943 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____
that I saw him/her alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 Robert McJeerath Probate Judge
Address Jarvisington Mo. (M. D. or other) _____ Date signed 3-15-43

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

SUPPLEMENTARY

5-11292