No. 2
9-4-41
5-17-39

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

14021

State File No.

FILED APR 29 1943

Registration District No. 69 Primary Registration District No. ~~4-21~~ 5272 Registrar's No. 1

1. PLACE OF DEATH:

(a) County CHRISTIAN

(b) City or town Billings Rural Polk
(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 LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County CHRISTIAN 22

(c) City or town RURAL POLK
(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 Mathilda Marie Louise Hering

3. (b) If veteran, name war ✓ 3. (c) Social Security No. —

4. Sex Female 5. Color or race White 6. (a) ~~Single~~, widowed, ~~married~~, 2 ~~divorced~~ widow

6. (b) Name of husband or wife Julius Hering 6. (c) Age of husband or wife if alive Died years

7. Birth date of deceased May (Month) 13th (Day) 1869 (Year)

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace Ind (City, town, or county) 1 (State or foreign country)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name Henry Blulbaum 4
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. Edna Ebert
(b) Address Billings, Mo.

17. (a) Germania Un (Burial, cremation, or removal) (b) Date thereof 3 (Month) 31st (Day) 1943 (Year)
(c) Place: burial or cremation German Cemetery

18. (a) Signature of funeral director A S Wallace
(b) Address Billings Missouri

19. (a) March 31 (Date received local registrar) (b) Mary F Spears (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1943 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from June, 1940 to March, 1943
that I last saw her alive on March 29th, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Terminal pneumonia	4 days
Due to Chronic nephritis	Several yrs.
Due to	
Other conditions Fractured r. femur (Include pregnancy within 3 months of death)	5 months

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 2 ✓

23. Signature R. W. Marshall (M. D. or other) D.O.
Address Billings, Mo. Date signed 4/31/43

1249 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 443-82
Date Filed APR 28 1943

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 me

Registered Apprentice No.

working under my personal supervision.

For Wallace Funeral Ho

Signed C. T. Lloyd

Licensed Embalmer No. 3527

P. O. Address Billings 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
DM—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. 14021

Registration District No. 69 Primary Registration District No. 5272 Registrar's No. 1

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Christian

(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 life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian

(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 Mathilda M. L. Hering

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 13 (Day) 1864 (Year)

8. AGE: Years 73 Months — Days 16 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 Mch day 29
year 1943 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 Fractured rt femur (Include pregnancy within 3 months of death)	5 mo.

Major findings:
Of operations 186a
Of autopsy 18

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 022
(b) Date of occurrence Nov. 30, 1942
(c) Where did injury occur? Billings (City or town) Christian (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home (Specify type of place) fall
While at work? no (e) Means of injury Step

23. Signature R. W. Marshall (M. D. or other) D.O.
Address Billings, Mo. Date signed