

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14234

FILED MAY 11 1943

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Washington, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Frances Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hours
(Specify whether years, months or days)

In this community All her life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Union, Mo. Rural
(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 Mary Frances Maune

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30 day March
year 1943 hour 8.00 minute _____ P.M.

21. I hereby certify that I attended the deceased from 3-1 1943, to March 30 1943
that I last saw her alive on 3-20-43 and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Edwin H. Maune 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased April 10, Mo. 1869
(Month) (Day) (Year)

Immediate cause of death:
Arterio sclerosis heart disease Duration 13 yrs

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 93d

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

23 II 18 hr. _____ min.

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name Charles Cierpiot

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

14. Maiden name Mary Eisermann

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

16. (a) Informant Edwin H. Maune

(b) Address Union, Mo.

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

(c) Place: burial or cremation West Hill Home

18. (a) Signature of funeral director _____

(b) Address Union, Missouri

19. (a) 4/1/43 (b) Lucille Ruethe
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature B. H. Stuhlman (M. D. or other) M.D.
Address Union, Mo. Date signed 3-31-43

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

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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..... *W. H. Horn*.....

Licensed Embalmer No. *3175*.....

P. O. Address. *Union, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14234

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 29

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 Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs (Specify whether
In this community life 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 Mary F Maune

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 Edmund 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased April 10 - 1869
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 8 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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 April 2 - 1943
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Wm N. Haun

(b) Address Union, Mo

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her live 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)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-14234