

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28185

State File No. _____

FILED SEP 9 1943 20

Registration District No. _____

Primary Registration District No. 4194

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Sentry

(b) City or town Albany
(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 _____ Six months (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Miss Catherine Rose Lerner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 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 May 19 = 1867
(Month) (Day) (Year)

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

76 2 28 hr. min.

9. Birthplace Lee County Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Studying and teaching music

11. Industry or business _____

12. Name S. P. Lerner

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

14. Maiden name Elizabeth Jane Post

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

16. (a) Informant Mrs. W. J. Martin

(b) Address Albany, Mo.

17. (a) Burial (b) Date thereof 8/19/43
(Burial, cremation, or reinterment) (Month) (Day) (Year)

(c) Place: burial or cremation Higglewood

18. (a) Signature of funeral director Clifford Brock

(b) Address Albany Mo

19. Aug 18-1943 (Date received local registrar) Thomas H. Martin (Registrar's signature)
Albany Mo (Address) Albany Mo (Date signed)

2. USUAL RESIDENCE OF DECEASED:

(a) State California (b) County _____

(c) City or town Beverly Hills
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17
year 1943 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from Mar 20
1943 to Aug. 17, 1943
that I last saw his alive on Aug 17, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) §30

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)

Means of injury _____

23. Signature W. J. Martin (M. D. or other) 8/15/43
Address Albany, Mo. Date signed 8/15/43

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

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.

Signed Richard Bush
.....
Licensed Embalmer No. 3329
P. O. Address Albany 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.