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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35216  
State File No.  
Registrar's No. 54

FILED NOV 5 1943

Registration District No. 208

Primary Registration District No. 4320

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution:  
Marion County Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 years  
(Specify whether years, months or days)

In this community 20 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 664

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

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

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Alvia Englehardt

3. (b) If veteran, name war 0 3. (c) Social Security No. 0

4. Sex Male 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 November 28 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>11</u>	<u>25</u>	_____ hr. _____ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Patient in Infirmary

12. Name Henry Englehardt

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

14. Maiden name Julia Weaver

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

16. (a) Informant Marion County Infirmary

(b) Address Palmyra, Mo. Records

17. (a) Burial (b) Date thereof 10/25/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Palmyra Cemetery

18. (a) Signature of funeral director Lewis Brown

(b) Address Palmyra, Mo.

19. (a) 10-24-43 (b) Mrs Margaret M. Miller  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct - day 23  
year 1943 hour 6 minute 20 M.

21. I hereby certify that I attended the deceased from Oct 22 to Oct 23, 1943,  
that I last saw him alive on Oct 23, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio sclerosis -

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions 97  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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) no

(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 E. M. Luck (M. D. or other)

Address Hainaut Date signed 10-25-43

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

MOTHER FATHER

**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..... *Leov. Lewis* .....

Licensed Embalmer No. *2383* .....

P. O. Address..... *Palmyra 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov  
Registrar's No. 54

Registration District No. 208

Primary Registration District No. (4320)

1. PLACE OF DEATH:

(a) County Monroe  
(b) City or town Rural (Liberty)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Monroe Co. Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution..... (Specify whether

In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Alois Englehardt

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

4. Sex M 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 Nov 28 (Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 28 (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) (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)

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 Nov day 23 year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him/her alive on..... 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

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:

(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.....

SUPPLEMENTARY

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

35216