

FILED DEC 10 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 5925

State File No. \_\_\_\_\_

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Perry  
(b) City or town Longtown Mo.  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry  
(c) City or town Longtown Mo.  
(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 Cora Kiefer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Lawrence Kiefer 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased November 18 1901  
(Month) (Day) (Year)

8. AGE: Years 42 Months 0 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John F. Bohnert  
13. Birthplace Berry Co. Missouri  
14. Maiden name Miteda Weinrich  
15. Birthplace Perry Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Lawrence Kiefer  
(b) Address Longtown Mo.

17. (a) Burial (b) Date thereof 11-30-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation mt. Hope cemetery

18. (a) Signature of funeral director Young & Sons  
(b) Address Perryville Mo.

19. (a) 11-29-43 (b) Thos. J. Elder  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27  
year 1943 hour 2 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Nov 1  
1943 to Nov 27 1943  
that I last saw her alive on Nov 20 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Arterio Sclerosis  
Due to \_\_\_\_\_

Due to by pulmonary

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? \_\_\_\_\_

23. Signature A. J. Miller (M. D. or other) \_\_\_\_\_  
Address Perryville Date signed 11/29/43

District Health Officer No. 4  
District File Number 1243-  
Date Filed 12-9-9

**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 Wallace Young  
Licensed Embalmer No. 4027  
P. O. Address Perryville

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**  
If this body is not embalmed, fact should be so stated above.

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Perry*  
(b) City or town *Longtown*  
(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 *Cora Kiefer*

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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive *39* years

7. Birth date of deceased *Nov. 18 - 1900*  
(Month) (Day) (Year)

8. AGE: Years *42* Months *0* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 *Nov* Day *7*  
Year *1943* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

*the primary hemorrhage*  
*hypertension*  
*malignant*

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 *Of Miller* (M. D. or other)

Address *Perryville Mo* Date signed *12/14/43*

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

SUPPLEMENTAL

38874