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FILED FEB 2 1944

State File No.

Registration District No. 178

Primary Registration District No. 5666

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Rural, Union
(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 49 Years, 3 Months, 29 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
(c) City or town Rural, Union
(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.....

3. (a) PRINT FULL NAME Freda Susan Eberhardt

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 Married
6. (b) Name of husband or wife Austin Eberhardt 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased September 28th, 1894
(Month) (Day) (Year)

8. AGE: Years 49 Months 3 Days 29 If less than one day
.....hr.min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Jobst Tiemann
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Maiera
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Laura Cooper
(b) Address La Grange, Missouri.

17. (a) Burial (b) Date thereof 1/30/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation La Grange, Missouri.

18. (a) Signature of funeral director M. Robert
(b) Address La Grange, Missouri.

19. (a) 1/29/44 (b) W. Jennings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27
year 1944 hour 8 minute 00 P.M.

21. I hereby certify that I attended the deceased from Dec 16, 1943, to Jan 27, 1944
that I last saw him alive on Jan 27, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death URAEMIA

Due to Nephritis & Influenza

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?

(Specify type of place) While at work? (c) Means of injury
Signature W. P. E. Jones (M. D. or other) MD
Address La Grange Mo Date signed 1/29/44

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

MOTHER FATHER

9870

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.....

A.A. Roberts.....

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. **1626**.....

P. O. Address..... **La Grange, Missouri**.....

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.

Registration District No. 178

Primary Registration District No. 5666

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(a) County Lewis
(b) City or town Rural Union Twp
(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 Freda Susan Eberhardt

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 _____ years

7. Birth date of deceased Sept 28 1902
(Month) (Day) (Year)

8. AGE: Years 49 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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) _____ (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 _____ Day _____ Year _____ Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death uraemia

Due to chronic nephritis & influenza

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 W. B. ... M.D. (M. D. or other) _____

Address Lat... .. Date signed 2/19/44

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

DEC 15 1944

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