

No. 2  
 1-23  
 5-17-39  
 X35697

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
**FILED MAR 6 1944**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

7125

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

Registration District No. 117

Primary Registration District No. 5435

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

1. PLACE OF DEATH:  
 (a) County GASCONADE  
 (b) City or town RURAL BOEUF TWP.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
NEAR DRAKE  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community 77 YEARS.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County GASCONADE  
 (c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
 (d) Street No. DRAKE  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY LOUISE GREUNKE  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month JANUARY day 10  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from  
1-8, 1944, to 1-11, 1944,  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
 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 WIDOWED  
 6. (b) Name of husband or wife CARL GREUNKE  
 6. (c) Age of husband or wife if alive DEAD years  
 7. Birth date of deceased JANUARY 4 1867  
(Month) (Day) (Year)

Immediate cause of death  
Pneumonia  
 Due to Myocardial Heart Lesion  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 77 Months 0 Days 6  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace DRAKE MISSOURI  
(City, town, or county) (State or foreign country)  
 10. Usual occupation HOUSE WORK

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
 12. Name FREDERICK HEIDORINK  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name HANNA RABENS  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant THEODORE GREUNKE  
 (b) Address DRAKE, MO.  
 17. (a) BURIAL (b) Date thereof 1 13 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation ST JOHN'S LUTHERAN CEM.  
 18. (a) Signature of funeral director Wilford N. H. Winter  
 (b) Address Quemerville, Mo.  
 19. (a) 1-13-1944 (b) Mrs F. B. Meyer  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Edna Mellin (M. D. or other) \_\_\_\_\_  
 Address Comerville, Mo. Date signed 1-13-44

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

120 ✓

RECEIVED  
District Health Officer No. 9,  
District File Number 39774  
Date Filed

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 Wilford Winter  
Licensed Embalmer No. 3838  
P. O. Address Quenville Ma

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. \_\_\_\_\_

Registration District No. 117

Primary Registration District No. 5435

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

1. PLACE OF DEATH:

(a) County Gasconade

(b) City or town Rural Boeuf 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 Mary Louie Gremb

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 W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan. 4 1886  
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Mo.  
(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 \_\_\_\_\_ 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 Pneumonia  
Bacterial Pneumonia

Duration \_\_\_\_\_

Due to Valvular lesion

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 107

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 \_\_\_\_\_

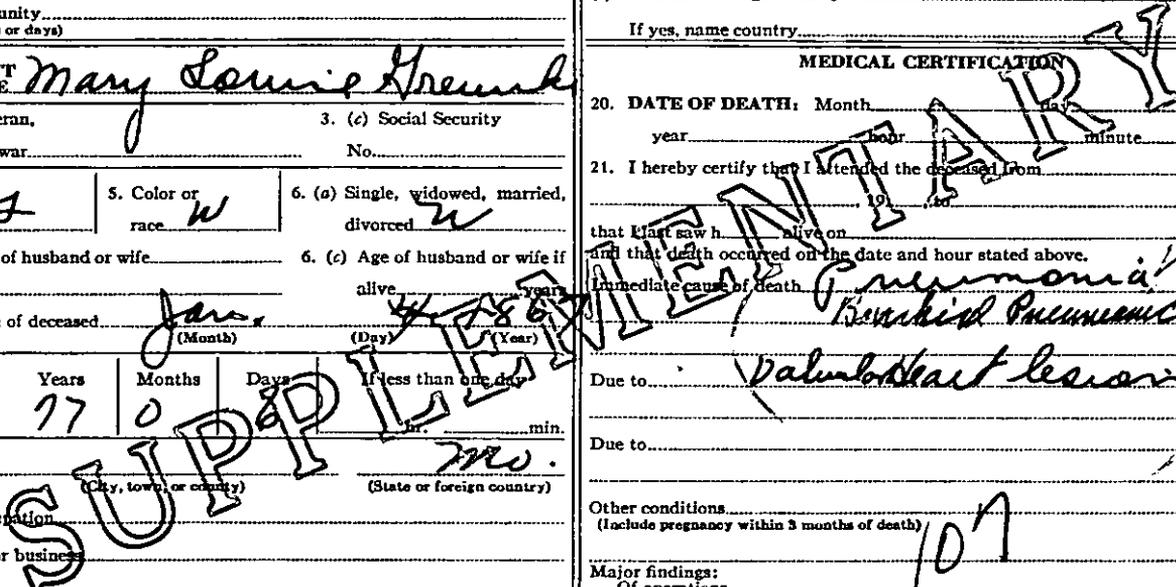
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



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MAR 2 91944