

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

75653

State File No.

FILED MAR 8 1944

Registration District No. 112

Primary Registration District No. 5642

Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Condon, Mo Rural
(c) Name of hospital or institution: Middleton road
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Rural-Middletown
(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 MRS. MARY VOLSTER

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 JOHN H VOLSTER 6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased 1 11 1862
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER } 12. Name Mrs. Eileen
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name MARY DETTINE
15. Birthplace Concordia Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Rania J. Kolster
(b) Address Waverly, Mo.

17. (a) Concordia (b) Date thereof 2 20 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Paul Cemetery

18. (a) Signature of funeral director Frederick + Wight
(b) Address Concordia Mo

19. (a) 2-17-1944 (b) Dr. W. A. Braacklein
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17
year 44 hour 1 minute 35 A.M.

21. I hereby certify that I attended the deceased from 2 - 13 1944 to 2 - 17-44, 19____
that I last saw her alive on 2/16/44, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia
Duration _____

Due to cerebral hemorrhage

Due to _____

Other conditions cerebral hemorrhage
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (Means of injury)

23. Signature Geo. J. Jones or other _____
Address Waverly, Mo. Date signed 2/17/44

RECEIVED

District Health Officer No. 8

District File Number

3-7-47

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *E. G. Perkins - F. E. Vaint*

Licensed Embalmer No. *2959 1511*

P. O. Address *Concordia 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. _____
Registral's No. 11

Registration District No. 172 Primary Registration District No. 5642

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Madison
(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 _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Madison Township
(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 Mary Kolster
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 Jan 11 1906
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days no (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 _____ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day _____ Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 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 _____

Due to hypostatic pneumonia

Due to bronchial infection

Other conditions cerebral hemorrhage
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Dr. J. J. ... (M., D., or other) _____

Address Waverly, Mo. Date signed 3/19/44

SUPPLEMENTARY INFORMATION REQUESTED

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

FILED MAR

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