

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

Robnett 14094
State File No.

FILED APR 20 1944

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 89

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
In this community 1 Day
years, months or days (Specify whether)

3. (a) PRINT FULL NAME RUTH MORGENTHALER

3. (b) If veteran, name war None 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 William Morgenthaler 6. (c) Age of husband or wife if alive years

7. Birth date of deceased 6 - 21 - 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 10 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business

12. Name William H. Brink

13. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Isabella Nowell

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

16. (a) Informant Mrs. W.I. McBride

(b) Address Columbia, Mo.

17. (a) Removal (b) Date thereof 4-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo.

18. (a) Signature of funeral director Barry Funeral Service
(b) Address Columbia, Mo.

19. (a) 4-1-1944 (b) Edna H. Barber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Hallsville
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 31
year 1944 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from 9-30, 1944, to 3-31, 1944.

that I last saw her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Rt. femur Duration 1 day

Due to Shock & Cerebratory failure (day)

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) Accident

(b) Date of occurrence 3-30-44

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

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

While at work? No (Specify type of place) (e) Means of injury

23. Signature W. E. Robnett (M. D. or other) MD
Address Columbia Mo Date signed 4/1/44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-18-44

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.....

.....
working under my personal supervision.

Registered Apprentice No.
Signed *Chris. Rapana*
Licensed Embalmer No. *4139*
P. O. Address *Cambridge, Mass.*

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. may
Registrar's No. 89

Registration District No. 28 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Bacon
(b) City or town Columbia
(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

3. (a) PRINT FULL NAME Ruth Morgenthau
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 _____

7. Birth date of deceased June 21 1886
(Month) (Day) (Year)

8. AGE: Years 74 Months _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (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 May Day 3
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death fracture right femur

Due to shock & circulatory failure 1 day

Due to _____ 1 day

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

Major findings: Of operations _____ Of autopsy _____
PHYSICIAN 1800
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) Accident
(b) Date of occurrence 3/30/44
(c) Where did injury occur? Hillsdale Home MO (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
While at work? _____ (Specify type of place) (e) Means of injury Fallen over
23. Signature W. Dobson (M. D. or other) W. Dobson
Address _____ Date signed _____

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

SUPPLEMENTAL

TEMPORARY

14094