

FILED MAY 3 1944

Registration District No.

Primary Registration District No. 3817

1. PLACE OF DEATH:

(a) County **COOPER**
(b) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **17-4rs**
(Specify whether
In this community **17 YEARS**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER**
(c) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL")
(d) Street No. **ST. JOSEPH'S HOSPITAL**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **SISTER M. MECHTILDE KIRCHNER O.S.B.**

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, **SINGLE**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **JULY 24 1861**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 8 27 hr. min.

9. Birthplace **HERMANN MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **RELIGIOUS NUN**

11. Industry or business **ORDER OF ST. BENEDICT**

MOTHER FATHER

12. Name **UNKNOWN**
13. Birthplace **?**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **?**
(City, town, or county) (State or foreign country)

16. (a) Informant **HOSPITAL RECORDS**

(b) Address **BOONVILLE, MO.**

17. (a) **BURIAL** (b) Date thereof **April 22, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LOURDOS SHRINE**

18. (a) Signature of funeral director **WEGNER & KOENIG**

(b) Address **BOONVILLE, MO.**

19. (a) **Apr. 24-44** (b) **Dr Chas. Swap,**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **APRIL** day **20th**
year **1944** hour **12:02** minute **P. M.**

21. I hereby certify that I attended the deceased from **Jan 10** to **Apr 20**, 19**44**
that I last saw her alive on **Apr 19**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular accident** Duration **4 hrs**
Due to **Arterial hypertension** **47 yrs**

Other conditions **Chronic myocarditis** ?
(Include pregnancy within 3 months of death)

Major findings: Of operations **None**
Of autopsy **None** **9/28**
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 **W. W. ...** (M. D. or other) **M.D.**
Address **Boonville, Mo** Date signed **4/24/44**

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

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

5-2-44

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.....

..... Registered Apprentice No.

working under my personal supervision.

Signed..... *James W. Sigurd*

..... Licensed Embalmer No. *3780*

..... P.O. Address: *Boonville, 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.