

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural Union
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Magdalene Adelhardt

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 March 7 1852
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>1</u>	<u>21</u>	hr. — min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER

12. Name Herman Parst

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Anton Maeller
(b) Address Beaufort Mo

17. (a) Burial (b) Date thereof May 1 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Neier Mo

18. (a) Signature of funeral director G. F. Jensen
(b) Address Beaufort Mo

19. (a) 4/30-1944 (b) Donald C. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. 82 yrs 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 28
year 1944 hour 7 minute 1 M.

21. I hereby certify that I attended the deceased from May 10 1944 to Apr 28 1944
that I last saw her alive on Apr 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis
Asthma

Due to _____

Due to _____

Other conditions General Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: No operation

Of operations _____

Of autopsy No 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? Y (Specify type of place)
L. Matheuse met (e) Means of injury

23. Signature L. Matheuse met (M. D. or other)
Address Beaufort Mo Date signed 4/28/44

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2
0-39
39
21492

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-15-44

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.....

E. H. Jenne

Registered Apprentice No.:

working under my personal supervision.

Signed

E. H. Jenne

Licensed Embalmer No.

3076

P. O. Address

Beaufort Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.