

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19218

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

FILED JUN 8 1944

Registration District No. 325

Primary Registration District No. 6090

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Sweet Springs  
(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 30 years  
years, months or days

3. (a) PRINT FULL NAME PAULINE LOUISE BRANDT

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife CHRIST BRANDT

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

7. Birth date of deceased MAR. 30. 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>		<u>23</u>	hr. _____ min. _____

9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business AT HOME

12. Name HENRY HEURMANN

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

14. Maiden name CLARA NORTBISCH

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

16. (a) Informant Bessie Brandt

(b) Address Sweet Springs Mo.

17. (a) Burial (b) Date thereof 4/25/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FAIRVIEW CEMETERY

18. (a) Signature of funeral director R C Carter

(b) Address Sweet Springs Mo.

19. (a) May 1-44 (b) Mrs. Doris Hoffmann  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

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

(d) Street No. Liberty 7284  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country Sweet Springs

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22  
year 1944 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1940  
\_\_\_\_\_ 19 \_\_\_\_\_ to Mar 22 1944  
that I last saw her alive on 18th 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis 4 days

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN [Signature]  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Chas P Benson (M. D. or other) MD  
Address Sweet Springs Mo. Date signed 4/22/44

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

MOTHER FATHER

RECEIVED

JUN 2 1944

FILED

6-2-44

**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 R C Carter

Licensed Embalmer No. 3513

P. O. Address Short Spring

**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.**

Registration District No. 323

Primary Registration District No. 6090

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Sweet Spring Mo  
(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.....  
In this community..... (Specify whether years, months or days) BRANDT

3. (a) PRINT FULL NAME Pauline J. Brandt

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.....

7. Birth date of deceased Mar - 30  
(Month) (Day) (Year)

8. AGE: Years 80 Months 13 Days 10 (If less than one day, in 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) May 1 - 44 (b) Mrs. Vera Hoffmann  
(Date registered 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 April day 2  
year 1944 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.....

Due to.....  
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).....

(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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

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

19218