

NO. 2  
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17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

**FILED JUN 26 1944**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22183

State File No. ....

Registration District No. 256

Primary Registration District No. 4388

Registrar's No. ....

1. PLACE OF DEATH: Osage

(a) County Osage

(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_  
years, months or days 58 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage 76

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) U  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Hoehner

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 Married

6. (b) Name of husband or wife F.W. Hoehner 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Aug 27 1883  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>8</u>	<u>6</u>	<u>10</u> hr. <u>05</u> min.

9. Birthplace Hermann Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Jacob Weber 4

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

14. Maiden name Kassia Rotfuch

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant F.W. Hoehner 1

(b) Address Chamois Mo

17. (a) Burial (b) Date thereof June 16 1944  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Chamois Evangelical Cemetery

18. (a) Signature of funeral director Otto T. Stokksick

(b) Address Chamois Mo

19. (a) June 15 1944 (b) Ethel Souder  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13  
year 1944 hour 10 minute 55 A.M.

21. I hereby certify that I attended the deceased from 5-20 1944 to 6-12 1944  
that I last saw her alive on 6-12 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration Duration 3 mo.

Due to Enlarged heart

Due to Essential Hypertension

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

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

93d

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? \_\_\_\_\_

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

23. Signature R. J. Jamworth (M. D. or other) DO.  
Address Chamois Mo Date signed 6-13-44

570

(Licensed Embalmer's Statement on Reverse Side)

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

[AUG 30 1954]

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 6-23-44

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, only  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Otto T. Stacksick  
Licensed Embalmer No. 1902  
P. O. Address Chamois md

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. 571

Registration District No. 256

Primary Registration District No. 4398

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Osage  
(b) City or town Chagnois  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Emma Holner

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 \_\_\_\_\_

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

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

8. AGE: Years 60 Months 8 Days \_\_\_\_\_ (Unless than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Esther Souder (Registrar's signature)  
(Date received local registrar)

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 \_\_\_\_\_ year 1944 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 \_\_\_\_\_

Duration

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

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

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

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

Of 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? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

22183