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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 25 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34639

State File No.

Registration District No. 129

Primary Registration District No. 4286

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town La Grange
(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 63 Years
years, months or days

3. (a) PRINT FULL NAME Anna Mary Sturhan

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. Widowed

6. (b) Name of husband or wife August Sturhan 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased April 26th 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 4 14 hr. min.

9. Birthplace Sutter Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business.....

12. Name William Henry Schrader

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

14. Maiden name Wilhelmina Musendick

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

16. (a) Informant Lana Sturhan

(b) Address La Grange, Missouri

17. (a) Burial (b) Date thereof 9/13/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Grange, Missouri.

18. (a) Signature of funeral director [Signature]
(b) Address La Grange, Missouri.

19. (a) 9/13/44 (b) P. W. Jennings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 10
year 1944 hour 2 minute 2 M.

21. I hereby certify that I attended the deceased from 9-6, 1944 to 9-10, 1944
that I last saw her alive on 9-10-44 and that death occurred on the date and hour stated above.

Immediate cause of death Flu Pneumonia Duration 4 days
Due to fracture of hip 3 mo.

Other conditions (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?

(Specify type of place) While at work? (e) Means of injury 2

23. Signature [Signature] (M. D. or other) Do

Address Carleton Mo Date signed 9-13-44

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

MOTHER FATHER

987

(Licensed Embalmer's Statement on Reverse Side)

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.....

A.A. Roberts

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. **1626**

P. O. Address **La Grange, Missouri.**

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. Nov

Registration District No. 178

Primary Registration District No. 286

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis

(b) City or town Le Stange
(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

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 _____

3. (a) PRINT FULL NAME Anna M. Sturhan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the day and hour stated above. Immediate cause of death The pneumonia

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 April 26
(Month) (Day) (Year)

Duration 4 days

Due to fracture of hip 8 mo
5-26-44

Due to _____

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ min.

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

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

1860-5

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)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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? at home (Specify type of place) _____ (e) Means of injury fall

23. Signature S. Hillard (M. D. or other) _____
Carleton Date signed _____

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

SUPPLEMENTARY INFORMATION REQUESTED

34639