

FILED NOV 13 1944

3038

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *Linn*
(b) City or town *Brookfield*
(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) *1*
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community *1 1/2* years (Specify whether years, months or days)

3. (a) PRINT FULL NAME *AMELIA LOUISA DIEMER*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 1 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Widow*
6. (b) Name of husband or wife *A. P. Diemer* 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *Oct - 20 - 1853*
(Month) (Day) (Year)

8. AGE: Years *90* Months *11* Days *17* If less than one day hr. _____ min. _____

9. Birthplace *Ohio* 1 (City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

11. Industry or business *Housewife*
12. Name *John Sylvibus*
13. Birthplace *Pa.* 1 (City, town, or county) (State or foreign country)
14. Maiden name *D.K.*
15. Birthplace *D.K.* 9 (City, town, or county) (State or foreign country)

16. (a) Informant *Blifford Diemer* 1
(b) Address *Brookfield Mo*
17. (a) *Burial* (b) Date thereof *Oct - 9 - 1944*
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation *Rose Hill*

18. (a) Signature of funeral director *Hill Funeral Home*
(b) Address *Brookfield*
19. (a) *10-9-1944* (b) *W. A. Cuman*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Linn* 58
(c) City or town *Brookfield* 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. *602 N - Down*
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* day *7*
year *1944* hour *6* minute *40* P.M.
21. I hereby certify that I attended the deceased from *Feb 10*
1944 to *Oct 7* 19*44*
that I last saw her alive on *Oct 6* 19*44*
and that death occurred on the date and hour stated above.

Immediate cause of death *Myocarditis* 10 mos
Nephritis 1 yrs.

Due to _____
Due to _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

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 *100*
23. Signature *W. B. Simpson* (M. D. or other) *100*
Address *Brookfield* Date signed *10-9-44*

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

MOTHER FATHER

RECEIVED
OCT 30 1956

OCT 30 1956

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 *J. H. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield Ma*

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. _____

Registration District No. 104

Primary Registration District No. 3038

Registrar's No. 377

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Brookfield
(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 Amelia L. Deemer

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 _____ year

7. Birth date of deceased Oct 20 1893
(Month) (Day) (Year)

8. AGE: Years 90 Months 11 Days _____ If less than one day _____ min.

9. Birthplace Ohio
(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 _____
(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)

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 Oct year 1944 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 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 myocarditis Duration 107mo

Due to nephritis chronic 5yrs.

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

Major findings: 131
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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. B. [unclear] (M. D. or other) DO

Address Brookfield Mo Date signed 11-16-44

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

SUPPLEMENTARY

341060