

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41428
State File No.

FILED JAN 12 1945
Registration District No. 142

Primary Registration District No. 5640

Registrar's No. 76

1. PLACE OF DEATH:

(a) County LAFAYETTE
(b) City or town CONCORDIA, MO. DAVIS TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 55 YEARS
years, months or days (Specify whether)

3. (a) PRINT FULL NAME ENGEL AHRENTSCHILD

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 26 years (Day) (Year)

7. Birth date of deceased MAY (Month) 26 (Day) 1857 (Year)
8. AGE: Years 87 Months 7 Days 5 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE RETIRED

11. Industry or business

12. Name FRIEDRICH ECKHOFF
13. Birthplace GERMANY (City, town, or county) (State or foreign country) 4
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country) 9

16. (a) Informant SARANA Y. AHRENTSCHILD
(b) Address CONCORDIA, MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN - 4 - 1945 (Month) (Day) (Year)

(c) Place: burial or cremation ST PAULS CEMETERY

18. (a) Signature of funeral director E. S. JAMES

(b) Address CONCORDIA, MO

19. (a) 1-1-1945 (Date received local registrar) (b) Dr. W. A. Brauckman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. 611 NORTH Y. WEST CONCORDIA MO
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 31 year 1944 hour 8 minute 30 PM.

21. I hereby certify that I attended the deceased from September 1, 1943 to Dec 31, 1944
that I last saw him alive on Dec 31, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Chronic Bronchitis
Due to —
Due to —

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

Major findings: Of operations — Of autopsy —
106 b
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 Edmund Brauckman (Date signed) 1/1/45
Address CONCORDIA, MO

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-10-45

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

E. S. Jones

Licensed Embalmer No. 2058

P. O. Address

Concordia Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Jan 76

Registration District No.

172

Primary Registration District No.

5640

Registrar's No.

1. PLACE OF DEATH:

- (a) County *Tazewell*
(b) City or town *Rural Davis Twp.*
(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

Engel Ahrentschult

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex *F*
race *W*

5. Color or

6. (a) Single, widowed, married,
divorced *W*

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive *26* years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

87

7

3

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) (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) (Date received local registrar)

(b) *Dr. W. A. Braecklen*
(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. *6 Mi. N.W. of Concordia*
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec*
year *1944* hour *10* minute *31* M.

21. I hereby certify that I attended the deceased from
that I last saw him alive on
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 sta-
tistically.

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

41428