

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1943

Registration District No. 59

Primary Registration District No. 4099

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Pleasant Hill, 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 70 years (Specify whether years, months or days)
In this community 70 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
(c) City or town Pleasant Hill, MO.
(If outside city or town limits, write "RURAL")
(d) Street No. 204 West Main (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME

Katherine Schmoll Kerche

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 marrie

6. (b) Name of husband or wife Chas. Kercher / 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Oct. 18 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>2</u>	<u>13</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Tobias Schmoll
13. Birthplace Hausen, Germany
(City, town, or county) (State or foreign country)
14. Maiden name Johanna Brechheimer
15. Birthplace Marnshans, Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Kercher

(b) Address Pleasant Hill, Missouri

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill, Mo.

18. (a) Signature of funeral director Allen Brownfield

(b) Address Pleasant Hill, Mo.

19. (a) Jan. 13, 1945 (b) Margaret Volla
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1
year 1945 hour 5 minute 9 M.

21. I hereby certify that I attended the deceased from Dec. 18 1944 to Jan 1 1945

that I last saw her alive on Jan 1 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 12/24/44

Due to Hypertension + Sclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 730

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 0

23. Signature V. Murray MD (M, D, or other)

Address Pleasant Hill, Mo. Date signed 1/13/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1047

(Licensed Embalmer's Statement on Reverse Side)

OCT 28 1948

MAR 11 1949

JAN 20 1949

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.....

By me 1-1-45....., Registered Apprentice No.....
working under my personal supervision.

Signed *Allen Brownfield*
Licensed Embalmer No. *3785*
P. O. Address *Pleasant Hill*

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 DEATHState File No. FebRegistration District No. 59Primary Registration District No. 4099Registrar's No. 8

1. PLACE OF DEATH:

- (a) County Cass
 (b) City or town Pleasant Hill
 (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 Katherine S. Kicher

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 m

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

7. Birth date of deceased Oct 18
(Month) (Day) (Year)8. AGE: Years 74 Months 2 Days _____ If less than one day, _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) Ohio

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 (Burial, cremation, or removal) (b) Date thereof 1-3-45
(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 Jan year 1945 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

S-1943