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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 10 1945

Primary Registration District No. 5795

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural Prairie J.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Norhones Mo. Route 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Twenty Eight years
years, months or days

3. (a) PRINT FULL NAME Fred Rengelman

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Roxie Rengelman 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased March 19 1878
(Month) (Day) (Year)

8. AGE: Years 70 Months - Days 26 hr. _____ min. _____

9. Birthplace Carroll County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Dietrich Rengelman

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

14. Maiden name Lena Dorn

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

16. (a) Informant Roxie Rengelman

(b) Address Norhones Mo.

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

(c) Place: burial or cremation Fairbairn Cemetery

18. (a) Signature of funeral director John S Dutch

(b) Address Norhones Mo.

19. (a) 4-15-45 (b) John S Dutch Dep.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

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

(d) Street No. Route 1
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 14
year 1945 hour 9-30 minute A.M.

21. I hereby certify that I attended the deceased from crushed by tractor 1945
that I last saw him alive on 4-13-45 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Crushed by tractor
Duration _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

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? 1

While at work? 1 (Specify type of place) (e) Means of injury 1

23. Signature B. C. Cole (M. D. or other) _____

Address Norhones Mo. Date signed 4-15-45

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

Serial File Number

Date Filed

5/19/45

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 ME

Registered Apprentice No.

working under my personal supervision.

Signed

John Deitch

Licensed Embalmer No. 3654

P. O. Address Norburn 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 46

Registration District No. 55

Primary Registration District No. 5195

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Rural Prineburg
(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 Fred Remyeman
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 mar 19 (Month) (Day) (Year)

8. AGE: Years 70 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town R.R. (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? m (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1945 hour _____ 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 Crushed by tractor backing up under a piece of timber in garage at his home. He tripped due to north of Norborne Mo at his home. 4-14-1945

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

Major findings: Of operations _____
Of autopsy Hot 2/6 19
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 Be. Case (M. D. or other) _____

Address Norborne Mo Date signed 5-14-45

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

SUPPLEMENTARY

13085