

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13351**
Registrar's No. **10**

FILED MAY 4 1945
Registration District No. **107**

Primary Registration District No. **4193**

1. PLACE OF DEATH:
(a) County **Gasconade**
(b) City or town **Hermann** *Roskemp*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Workmann Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 days**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Clara Alexander**
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 **Wm. Alexander**
6. (c) Age of husband or wife if alive **10** years
7. Birth date of deceased **Aug. 10 1873**
(Month) (Day) (Year)

8. AGE: Years **71** Months **8** Days **17**
If less than one day
hr. min.

9. Birthplace **High Hill Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **Samual Whitmann**

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

14. Maiden name **Stewart**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Viola Algeyer**

(b) Address **Mc Kittrick, Mo.**

17. (a) **Burial** (b) Date thereof **4/29/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Price's Branch**

18. (a) Signature of funeral director **H. H. H. H.**

(b) Address **Hermann, Mo.**

19. (a) **April 28/45** (b) **a. H. Lieder**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **70**
(a) State **Mo.** (b) County **Montgomery**
(c) City or town **R. F. D. Mc Kittrick, Mo.**
(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 **April** day **27**
year **1945** hour **1** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **4/13** to **4/27**, 1945
that I last saw her alive on **4/27**, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy**
Due to _____

Due to **gsw**
Other conditions **Hypertension**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 **Howard H. H. H.** (M. D. or other)

Address **Hermann Mo.** Date signed **4/27/45**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-2-45

561 02 NNR

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

Licensed Embalmer No. 2044

P. O. Address Hermann, 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.