

No. 2
-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

84086

State File No. _____

FILED NOV 1 1945

Primary Registration District No. 4213

Registrar's No. 13

1. PLACE OF DEATH:

(a) County LAFAYETTE

(b) City or town CONCORDIA
(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 years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE 54

(c) City or town CONCORDIA
(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 _____

3. (a) PRINT FULL NAME HERMAN MAHNKEN

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHT

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: 4 (Month) 17 (Day) 1857 (Year)

8. AGE: Years 88 Months 6 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation RETIRED LINDSBOGIC DENA

11. Industry or business _____

12. Name LOUIS MAHNKEN

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

14. Maiden name _____

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

16. (a) Informant Arthur Mahnken

(b) Address Concordia 2nd

17. (a) St Pauls (b) Date thereof 11-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Pauls 11-2-45

18. (a) Signature of funeral director Feering + Veigt

(b) Address Concordia 2nd

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30 year 1945 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from Aug 10-45 to Oct 30, 1945; that I last saw him alive on Oct 30, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure

Due to carcinoma of Mouth

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none 450

Duration _____

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 Dorland Shryman (M. D. or other)

Address Concordia 1 Mo Date signed 11-1-45

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

MOTHER FATHER

1562

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 11-9-68

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. P. Greking J. C. Vaint
#2959 1514
Licensed Embalmer No.....
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. nov
Registrar's No. 13

Registration District No. 173 Primary Registration District No. 4273

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Concordia
(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)

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 _____

3. (a) PRINT FULL NAME Herman Mahruken
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Apr 12 (Month) (Day) (Year)

8. AGE: Years 88 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) Germany (State or foreign country)

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Nov 1-1945 (b) Ferdinand Shryman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 10 Year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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 _____

SUPPLEMENTARY

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

34086