

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41149**

Registrar's No. **12**

FILED JAN 11 1945
Registration District No. **117**

Primary Registration District No. **5436**

1. PLACE OF DEATH:
(a) County **GASCONADE**
(b) City or town **RURAL BOWLING GREEN**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **OWENSVILLE 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 **SEVERAL MONTHS**
years, months or days

3. (a) PRINT FULL NAME **EMMA HELEN BERKEMEYER**
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 **SINGLE**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JUNE 5 1908**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
37 6 0 hr. min.

9. Birthplace **HOPE MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business **"**

12. Name **FRED BIRKEMEYER**
13. Birthplace **HOPE MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **MINNIE KRETER**
15. Birthplace **HOPE MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **LOUIS BERKEMEYER**
(b) Address **OWENSVILLE MO. R 2**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **DEC. 9 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **SALEM PRESB. HOPE MO**

18. (a) Signature of funeral director **MILFORD WINTER**

(b) Address **OWENSVILLE MO.**

19. (a) **12/8/45** (Date received local registrar) (b) **Mrs. Ray Schaeperkotten** (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **DEC.** day **5**
year **1945** hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Dec 4th**, 19**45**, to **Dec 5th**, 19**45**,
that I last saw her alive on **Dec 4th**, 19**45**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Uterus**

Due to _____
Due to _____

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

Major findings: Of operations **48.1**
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? _____

(Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature **E. G. Rhodius** (M. D. or other) **Dr.**
Address **Hermann Mo** Date signed **12/7/45**

(Licensed Embalmer's Statement on Reverse Side)

1595

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-10-46

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 M.

....., Registered Apprentice No.....
working under my personal supervision.

Signed Melvin Winter

Licensed Embalmer No. 3835

P. O. Address Quincyville 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
Registrar's No. 12

Registration District No. 117

Primary Registration District No. 5436

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Rural
(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 Emma H. Berkenmeyer

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 S

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

7. Birth date of deceased June 5, 1906
(Month) (Day) (Year)

8. AGE: Years 37 Months 6 Days 20 If less than one day hr. 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 (City, town, or county) (State or foreign country)

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 (b) County
(c) City or town Owensville, Mo. (Rural)
(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 day year hour minute M.

21. I hereby certify that I attended the deceased from to 19 that I last saw him alive on 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

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

41149