

**FILED** JAN 9 1946 **STANDARD CERTIFICATE OF DEATH**

Registration District No. **274**

Primary Registration District No. **4408**

Registrar's No. **366**

**1. PLACE OF DEATH:**

(a) County **Pettis**  
(b) City or town **Smithton mo**  
(c) Name of hospital or institution: **none**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5 1/2 weeks**  
In this community **5 weeks**  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **mo** (b) County **Morgan**  
(c) City or town **Flournoe mo**  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? **no**  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME**

**Anna Sophia Cechurke**

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

4. Sex **F**

5. Color or race **W**

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

6. (b) Name of husband or wife **Henry**

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

7. Birth date of deceased. **Nov 10 - 1867**  
(Month) (Day) (Year)

**8. AGE:**

Years **78** Months **1** Days **18**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace**

**Flournoe Morgan Co. mo**  
(City, town, or county) (State or foreign country)

**10. Usual occupation**

**House wife**

**11. Industry or business**

**Christian Kurtz**

**12. Name**

**Christian Kurtz**

**13. Birthplace**

**Germany**  
(City, town, or county) (State or foreign country)

**14. Maiden name**

**Anna Beksdorfer**

**15. Birthplace**

**Germany**  
(City, town, or county) (State or foreign country)

**16. (a) Informant**

**Angie Cechurke**

**(b) Address**

**Smithton mo**

**17. (a) Burial**

**12-30-45**  
(Date received local registrar) (Month) (Day) (Year)

**(c) Place: burial or cremation**

**Flournoe mo**

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

**D. F. Neumann**

**(b) Address**

**Smithton mo**

**19. (a) 1-4-46**

(Date received local registrar)

**(b) [Signature]**

(Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH: Month 28 day Dec year 1945 hour 5 minute 30 a.m.**

**21. I hereby certify that I attended the deceased from Dec 20 to Dec 28 1945 and that death occurred on the date and hour stated above.**

**Immediate cause of death**

**Apoplexy**

**Due to**

**Hypertension**

**Due to**

**Other conditions**

(Include pregnancy within 3 months of death)

**Major findings**

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**Duration**

**4 days**

**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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

**While at work?**

Signature **Patty Fogle** (M. D. or other) **mo**  
Address **Osborne mo** Date signed **12/30/45**

1486

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-8-46.....

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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 A. F. Neumann.....

Licensed Embalmer No. 3912.....

P. O. Address Smithton 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 CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 42099Registration District No. 274Primary Registration District No. 4408Registrar's No. 366

## 1. PLACE OF DEATH:

(a) County Putnam  
(b) City or town Smithton  
(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 whetherIn this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME Arina Sophia Oehrke3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F 5. Color or race W  
6. (a) Single, widowed, married,  
divorced wid6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if  
alive \_\_\_\_\_7. Birth date of deceased no. 18  
(Month) (Day) (Year)8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_  
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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) A. J. Campbell  
(Date received local registrar) (Signature of signatory)

## 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 \_\_\_\_\_ Day \_\_\_\_\_  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_  
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 \_\_\_\_\_

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 sta-  
tistically.

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

MOTHER, FATHER

