

FILED FEB 15 1946
Registration District No. **208**

Primary Registration District No. **5760**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Rabius Township /**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **life time** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Marion** **64**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. **Rabius Township**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Minnie Angelin Ahland**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No.**

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

6. (b) Name of husband or wife **Carl R. Ahland** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **November 5 1891**
(Month) (Day) (Year)

8. AGE: Years **54** Months **2** Days **0** If less than one day hr. min.

9. Birthplace **Warsaw Illinois /**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business _____

12. Name **Franklin B. Dietle**
13. Birthplace **Lima Illinois /**
(City, town, or county) (State or foreign country)

14. Maiden name **Barbara Gollmer**
15. Birthplace **Warsaw Illinois /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret Ahland**

(b) Address **Palmyra, Missouri**

17. (a) **Burial** (b) Date thereof **1/16, 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address **Palmyra, Missouri**

19. (a) **1-17-1946** (b) **L. Boone Deputy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **13**
year **1946** hour **5** minute **55** M.

21. I hereby certify that I attended the deceased from **February 1-13 1946** to **Jan 13 1946**
that I last saw her alive on **Jan 13 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Multiple Carcinoma of**
gall. tract pt. tumorous
left lung, Pleurisy
& heavy ribs, 9th thoracic
& 5th lumbar vertebrae
Duration _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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) _____ **64**
(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 **A. B. Moss** (M. D. or other)
Address **Palmyra Mo.** Date signed **1/16/46**

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

1584

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

Licensed Embalmer No.

P. O. Address.

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.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 726
Registrar's No. 2

Registration District No. 208 Primary Registration District No. 5760

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

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Rural Fairbury
(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 Minnie A. Ahland

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 m

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

7. Birth date of deceased in (Month) 5 (Day) 1904 (Year)

8. AGE: Years 54 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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 1944 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 This woman had cancer of multiple myeloma involving vertebrae, ribs, sternum, pelvis, neck & humerus & left femur. There is no history of an injury. Condition probably began about 1940 with back pain.

Other conditions (If include pregnancy within 3 months of death) _____
Major findings: _____
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 _____

1584

SUPPLEMENTARY 3

3290