DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30886

FILED SEP 17 1946

Registration District No. _____ Primary Registration District No. 5-667 Registrar's No. 48

1. PLACE OF DEATH:

(a) County: LINCOLN

(b) City or town: RURAL (BEDFORD TWP.)
(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: Missouri (b) County: Lincoln 57

(c) City or town: RURAL (BEDFORD TWP.) 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME: ELFIE LEE RINAMAN

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: ELMER RINAMAN.

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

7. Birth date of deceased: OCT. (Month) 2 (Day) 1893 (Year)

8. AGE: Years 52 Months 11 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace: LINCOLN Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business _____

MOTHER FATHER

12. Name: Hurley TRAIL

13. Birthplace: LINCOLN Co. (City, town, or county) Missouri (State or foreign country)

14. Maiden name: MARGARET ANN TRAIL

15. Birthplace: Lincoln Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs T. W. Smith

(b) Address: Troy, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: SEPT. 10. 1946 (Month) (Day) (Year)

(c) Place: burial or cremation: TROY, Missouri.

18. (a) Signature of funeral director: Hempen Funeral Home

(b) Address: Troy. Mo.

19. (a) Sept 16 (Date received local registrar) (b) 46 Mrs Emma B. Riddle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 8 year 1946 hour 9. minute 30 P.M.

21. I hereby certify that I attended the deceased from 8/16, 1945 to 9/8, 1946 that I last saw him alive on 9/8 - 1946, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	5 days
Due to: Chronic Mylitis	
Due to:	
Other conditions: Chronic Cystitis (Purulent) (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____
Of autopsy: 82

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? 0
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature: J. G. Hoeger (M. D. or other) M.D.

Address: Whiteside Mo. Date signed 9/8-1946

162 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number 9-46-45-3
Date Filed 9-18-46

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Joseph J. Marsh

Licensed Embalmer No. 3932

P. O. Address Troy, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 48

1. PLACE OF DEATH:

(a) County: Lincoln

(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 years, months or days)

In this community

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: Elfie Lee Runama

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: Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased: Oct 2 1889 (Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 6 If less than one day hr. min.

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

10. Usual occupation: Housewife

11. Industry or business: Farmers widow

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) (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) Mrs. Emma B. Pillie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 8 year 1956 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

30886