

No. 2
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K36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 28 1946 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32575**
Registration District No. **2** Primary Registration District No. **3014** Registrar's No. **97**

1. PLACE OF DEATH:

(a) County **Andrew Co.**
(b) City or town **Jefferson RURAL**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **RFD # 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **23 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Andrew**
(c) City or town **RFD # 3 - Rural - 0**
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Joseph** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MARGARET-SUSAN-KURZ**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

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 **Sept. 19 - 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
23 hr. min.

9. Birthplace **St. Joseph Andrew Mo. U**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business

12. Name **Verion Kurz**

13. Birthplace **Verion Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Mrs. A. Jennings**

15. Birthplace **Andrew Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Verion Kurz**

(b) Address **R.R. # 2, St. Joseph, Mo.**

17. (a) **B** (b) Date thereof **10-12-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. John's Ev. Reformed Ch., Annapolis, Mo.**

18. (a) Signature of funeral director **Stacey Funeral Home**
(b) Address **St. Joseph Mo.**

19. (a) **10-15-46** (b) **William Spark**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **12** year **1946** hour **31** minute **0** M.

21. I hereby certify that I attended the deceased from **Schvig** 19 **46** to **Oct 12** 19 **46**
that I last saw her alive on **Oct 11** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Premature Twin Congenital Heart Disease**
Due to **Disease**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none** Of autopsy **none**

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) (c) Means of injury

23. Signature **W. Ross Marie** (M. D. number) **0**
Address **St. Joseph Mo.** Date signed

Duration
13 da
13 da
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

11 a m
Du Ross, Mo.

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

not

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

1

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

working under my personal supervision.

Signed.....

Robert Roy Stamer

Licensed Embalmer No. *2835*

P. O. Address *St Joseph*

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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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 97

Registration District No. 2 Primary Registration District No. 5014

1. PLACE OF DEATH:

(a) County Andrew
(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 Margaret S Kurz

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 _____

7. Birth date of deceased Sept 19 1946
(Month) (Day) (Year)

8. AGE: Years _____ 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) _____ (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) 11-15-46 (Date received local registrar) (b) Lillian Sparks (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 Oct year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ after noon _____, 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? _____

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 2

32575