

Registration District No. 323

Primary Registration District No. 4474

Registrar's No. 1

1. PLACE OF DEATH:

(a) County SALINE

(b) City or town SWEET SPRINGS  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: N. LOCUST ST 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 LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SALINE 97

(c) City or town SWEET SPRINGS, 3  
(If outside city or town limits, write "RURAL")

(d) Street No. N. LOCUST ST 3  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SOPHIA ELSNER.

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30  
year 1946 hour 4 minute 2 M.

21. I hereby certify that I attended the deceased from investigated Jan. 1st 1947  
that I last saw him live on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

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

7. Birth date of deceased: DEC 25 1861  
(Month) (Day) (Year)

Immediate cause of death Stroke to death

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy No.

8. AGE: Years 85 Months \_\_\_\_\_ Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace SALINE Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business HOUSE KEEPING 4

12. Name ALG MEYER 4

13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

14. Maiden name HENERETA WAIKENHORST

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

16. (a) Informant W. MEYER

(b) Address CONCORDIA, Mo

17. (a) BURIAL (b) Date thereof 1/3/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FAIRVIEW CEMETERY

18. (a) Signature of funeral director R.C. CARTER

(b) Address SWEET SPRINGS, Mo

19. (a) 1/3/47 (b) Dolly Anderson  
(Date received local registrar) (Registrar's signature)

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 3

23. Signature P.L. Lawless, Coroner (M. D. or other) \_\_\_\_\_

Address Mass Rd Mo Date signed 1-47

MOTHER, FATHER

RECEIVED

District Health Officer No. 8,

District File Number .....

Date Filed 1-11-47

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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 P. C. Carter

Licensed Embalmer No. 3513

P. O. Address Chapel Hill, N.C.

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

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