

FILED FEB 11 1947

State File No.

Registrar's No. 20

Registration District No. 116

Primary Registration District No. 3020

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(c) Name of hospital or institution: St. Francis Hospital
(d) Length of stay: In hospital or institution 2 days
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Union
(d) Street No. Rural
(e) Citizen of foreign country? (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Louise Berghorn

3. (b) If veteran, name war _____ (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 _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 30th 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation House work

11. Industry or business _____

12. Name J. Henry Krueh

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

14. Maiden name Mabel Maunt

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

16. (a) Informant Adolph Berghorn

(b) Address Union Mo.

17. (a) Burial (b) Date thereof 2/7/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's

18. (a) Signature of funeral director: E. F. Ottman

(b) Address Union Mo.

19. (a) FEB 6 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 4th, year 1947 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 3 1947 to Feb 4th 1947, that I last saw her alive on 2-4- 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia
Due to: Cardiac Failure
Due to: Arterio-sclerotic Cardio-vascular disease
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration 3 days
3 days
1 year

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? _____
(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 [Signature] (M. D. or other) [Signature]
Address Union Mo. Date signed 2-6-47

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

RECEIVED
District Health Officer No. 9
State File Number
2-10-47

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 E. F. Ottmann

Licensed Embalmer No. 1686

P. O. Address Union 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.