

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JAN 30 1947

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

16336

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 170
 (b) Township Smith Primary Registration District No. 5633
 (c) City 1 (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William M. Archer</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 18 1852</u>		
7. AGE <u>95</u>	YEARS <u>95</u>	MONTHS <u>23</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>house wife</u>		9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Camden County, Mo</u>		
13. NAME <u>Emma Kieisinger</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
15. MAIDEN NAME <u>Mary Light</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>Skipp Archer, Stouffland Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Stouffland Cemetery</u> DATE <u>Jan 12 1947</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Wm. J. Edwards, Stouffland Mo</u>		
20. FILED <u>Jan 18, 1947</u> <u>Geo. Frankburger</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Jan - 10 1947</u>
22. HEREBY CERTIFY That I attended deceased from <u>July 10th 1946</u> to <u>Jan 10th 1947</u> I last saw him alive on <u>Jan 9th 1947</u> . Death is said to have occurred on the date stated above, at <u>11 P. M.</u> The principal cause of death and related causes of importance were as follows: <u>Cerebral Thrombosis and Senility</u> Date of onset <u>Unknown</u> Other contributory causes of importance: <u>4/32-5</u> Name of operation _____ Date of _____ What test confirmed diagnosis? <u>bedridden</u> Was there an autopsy? <u>no</u> 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury _____ Nature of injury _____ 24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify _____ (Signed) <u>C. E. Carlsberg</u> , M. D. (Address) <u>Stouffland Mo</u> <u>Jan 15, 1947</u>

Received 1/28/47
Laclede County Health Unit
File No. 1-47-2
Date Filed 1/28/47

STATEMENT BY LICENSED EMBALMER

I, W. J. G. Jones, Licensed Embalmer No. _____
hereby certify that the Body recorded on the reverse side of this certificate was ~~embalmed~~ Not Embalmed
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

W. J. G. Jones
Licensed Embalmer No. 2014

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.)