

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10187**

FILED APR 4 1947

Registration District No. **200**

Primary Registration District No. **4391**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **Osage**
(b) City or town **Argyle Mo**
(If outside city & 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 **Life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Osage**
(c) City or town **Argyle Mo**
(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 **Gertrude Brunner Brunner**

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 **John A. Brunner** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 22 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 26 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Martin Borgmeyer**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Marie HonKuhon**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Fritz Wieberg**
(b) Address **Argyle Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-22-47**
(Month) (Day) (Year)
(c) Place: burial or cremation **Argyle Mo**

18. (a) Signature of funeral director **Clyde Norton**
(b) Address **Argyle Mo**
19. (a) **3-22-47** (Date received local registrar) (b) **Mrs. H. H. Mease** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **18** year **1947** hour **1** minute **30** A. M.

21. I hereby certify that I attended the deceased from **March 8 1947** to **March 18, 1947**; (that I last saw her alive on **March 18, 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Left Ventricular failure** Duration _____

Due to **Myocarditis Hypertensoin** Yrs _____

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 **21**

23. Signature **W. H. Moore, D.O.** (M. D. or other) _____
Address **Argyle, Mo.** Date signed **3/19/47**

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

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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-2-47

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 *Vernon M. Morton*

Licensed Embalmer No. *4125*

P. O. Address *Leim*

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.