

No. 2
-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17897

State File No.

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 56

1. PLACE OF DEATH:

(a) County JOHNSON
(b) City or town WARRENSBURG
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WARRENSBURG CLINIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 DAYS
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE
(c) City or town CONCORDIA
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MATHILDA RIEFFEL

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 WIDOW

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased DEC 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED HOUSEWIFE

11. Industry or business _____

12. Name HENRY HEWERMANN

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

14. Maiden name UNKNOWN

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

16. (a) Informant CLARA SCHROEDER

(b) Address HIGGINSVILLE MO

17. (a) REMOVAL (b) Date thereof JUNE 1 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SWEET SPRINGS MO

18. (a) Signature of funeral director F. S. JAMES

(b) Address CONCORDIA MO

19. (a) 6-4-47 (b) Savannah Crest
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1 - 47
year 1947 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from May 15 '47
_____ 19____ to June 1-47 19____;
that I last saw h. ✓ alive on June 1-47 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Hemorrhage Duration 2 wks.

Due to metastatic ca - ?

Due to Ovarian carcinoma ?

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Dilated Mollusca PHYSICIAN _____
Of operations _____

Of autopsy HGA
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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. F. M. King (M. D. or other) MD

Address Waverly Mo Date signed 6-1-47

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

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 Ma

....., Registered Apprentice No. 2058
working under my personal supervision.

Signed E. S. James

Licensed Embalmer No. 2058

P. O. Address Cornelia M

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.