No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 7 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24963

Registration District No. 7

Primary Registration District No. 5880

Registrar's No.

1. PLACE OF DEATH:
(a) County Osage Crawford
(b) City or town Linn Mo Rd Twp
(If outside city or 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 years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Osage 76
(c) City or town Linn Mo R.D. 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anna Dorothy Kixmueller
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
6. (c) Age of husband or wife if alive years
7. Birth date of deceased January (Month) 1 (Day) 1867 (Year)

8. AGE: Years 80 Months 6 Days 27 If less than one day hr. min.

9. Birthplace Woolem (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Adolph Brandenberger
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Dorothy Tappe
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Henry Kixmueller
(b) Address Linn Mo. R.D.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation Freedom Mo
18. (a) Signature of funeral director Clyde Morton
(b) Address Linn Mo
19. (a) 7/31/1947 (Date received local registrar) (b) Za Immillet (Registrar's signature) 235

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 28 year 1947 hour 3 minute 15 p.M.

21. I hereby certify that I attended the deceased from 5-10-, 1947, to 6-20-, 1947; that I last saw her alive on 6-20-, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to Arteriosclerosis
Due to Chronic Interstitial Nephritis
Other conditions Fracture left femur 5/10/47
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature Norman W Baldwin (M.D. or other) D.O.
Address Linn, Mo Date signed 7/30/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9.
District File Number 8-6-47
Date Filed

AUG 23 1941

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 Lynn Me

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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 257 Primary Registration District No. 5880 Registrar's No.

1. PLACE OF DEATH:

(a) County: Osage

(b) City or town: Rural
(If outside city or 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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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: Anna O. Kipmueller

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan 1 (Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 8 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from, 19, to, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Fully recovered from fall.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 94P

Major findings:
Of operations
94P
Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-24963