

FILED AUG 14 1947

Registration District No. 2882

Primary Registration District No. 4234

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Warren  
(b) City or town Okemun Jay Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
County Farm 5  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Eme Ohlentoy

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years  
7. Birth date of deceased - (Month) (Day) (Year) 1888

8. AGE: Years 59 Months - Days - If less than one day hr. - min. -

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

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Unknown 9

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

14. Maiden name Unknown

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

16. (a) Informant Julius Jaspersen

(b) Address Wright City Mo

17. (a) Burial (b) Date thereof 7/1/47 (Month) (Day) (Year)

(c) Place: burial or cremation County Farm Cem

18. (a) Signature of funeral director Julius Jaspersen 7 & W

(b) Address Wright City Mo

19. (a) 8/7/47 (Date received local registrar) (b) Mr. Fred Moray (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. - (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7 year 1947 hour - minute - M.

21. I hereby certify that I attended the deceased from Aug 6 1947, to Aug 7 1947, that I last saw him alive on Aug 6 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration 5 days

Due to ✓

Due to ✓

Other conditions Various Infirmitates (Include pregnancy within 3 months of death)

Major findings: Of operations 12 B 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) (c) Means of injury 0

23. Signature John H. Dyer (M. D. or other) Address Wadenton, Mo Date signed 8-7-47

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

MOTHER FATHER

RECEIVED

Date Filed AUG 13 1947

District File Number

District Health Officer No. 9

JUL 9 1953

JUL 10 1953

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 362Primary Registration District No. 6234

## 1. PLACE OF DEATH:

- (a) County Warren  
 (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 \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME Emil Ohrentz

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 59 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County Montgomery  
 (c) City or town RURAL  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1987 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

