No. 2
1-1/479
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30161

FILED SEP 15 1947

Registration District No. 3926 — Primary Registration District No. 4536 — Registrar's No.

1. PLACE OF DEATH:
(a) County: Washington
(b) City or town: ~~Washington~~ Potosi
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(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: lifetime

2. USUAL RESIDENCE OF DECEASED: 94
(a) State: Missouri (b) County: St. Francois
(c) City or town: Farmington 4
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location) 1
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William Henry Herbst
3. (b) If veteran, name war: World War # 1
3. (c) Social Security No.
4. Sex: m 0
5. Color or race: w
6. (a) Single, widowed, married, divorced: m
6. (b) Name of husband or wife: Mary Henrietta Schrader
6. (c) Age of husband or wife if alive: 54 years
7. Birth date of deceased: June 22, 1886 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
61	1	29	..... hr. ..... min.

9. Birthplace: Farmington Missouri 0
(City, town, or county) (State or foreign country)
10. Usual occupation: ✓
11. Industry or business:
FATHER 12. Name: WM Herbst 0
13. Birthplace: Doe Run Mo
(City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Caroline Grotjohn 0
15. Birthplace: Iron Mountain
(City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Will Herbst
(b) Address: Farmington, Mo
17. (a) b (Burial, cremation, or removal) (b) Date thereof: 8-24-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Lutheran
18. (a) Signature of funeral director: C. H. Cozean
(b) Address: Farmington Mo.
19. (a) Aug 31 47 (Date received by local registrar) (b) Mrs C Thesauele (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 21 year: 1947 hour: 10 minute: 15 A.M.
21. I hereby certify that I attended the deceased from: Died Not ..... to ..... 19.....; that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Died 3 mins after reaching Potosi	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operation: 837	
Of autopsy:	

PHYSICIAN — Underline the cause of 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: L. F. Crunwell (M. D. or other)
Address: Potosi Mo Date signed: 8/22/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

OCT 14 1949

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. 408 F

P. O. Address. Farmington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2D
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. Sept

Registration District No. 366 Primary Registration District No. 4536 Registrar's No.

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Potosi
(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 Wm H. Herbert

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased June 22 (Month) (Day) (Year)

8. AGE: Years 61 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (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) Sept 20-47 (Date received local registrar) (b) Mrs. G. F. Crossnell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 21 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 — Duration

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-30161