

FILED DEC 30 1947

Registration District No. **238**

Primary Registration District No. **4344**

Registrar's No. **16**

1. PLACE OF DEATH:

(a) County Montgomery
 (b) City or town "Rural" Loutie
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1 mi. West of Mc Kittrick
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 4 years
years, months or days

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. 1 mi. West of Mc Kittrick
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ANNA ELSIA BUCHHOLZ

3. (b) If veteran, name war ---- 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Julius Buchholz 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Feb 25 1899
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 23
 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Bernard Heumann

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

14. Maiden name Louise Westholz

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

16. (a) Informant Julius Buchholz

(b) Address RFR Mc Kittrick, Mo

17. (a) Burial (b) Date thereof 12-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul Bay Cemetery

18. (a) Signature of funeral director Negost Steiner

(b) Address Hermann, Mo

19. (a) Dec. 19-47 (b) Miss Anna Lee Thompson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18th year 1947 hour 2 minute A M.

21. I hereby certify that I attended the deceased from Dec. 15th 1947 to Dec 18th 1947, that I last saw h. ex alive on Dec 17th 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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 E. G. Rhodius (M. D. or other) _____

Address Hermann Mo Date signed 12/19/47

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN Underline the cause to which death should be charged statistically.

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

~~Date Filed 12-29-47~~

District File Number

Local Health Officer No. 9,

RECEIVED

REC'D

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.....
August Blumer

Licensed Embalmer No. 3160

P. O. Address Hermann, Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan 16*
Registrar's No. *16*

Registration District No. *230*

Primary Registration District No. *4344*

1. PLACE OF DEATH:
(a) County *Montgomery*
(b) City or town *Royal*
(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 _____ (Specify whether _____)
years, months or days

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 E. Buckholz*
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *Jan* Day *18* Year *1947* 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 _____

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *in*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased *Feb. 2, 1891*
(Month) (Day) (Year)

Duration
Lobar Pneumonia 5 days
Due to *Common Cold*

8. AGE: Years *57* Months _____ Days _____ If less than one day hr. _____ min. _____
9. Birthplace _____ (City, town, or county) (State or foreign country) *MO*

Other conditions _____ (Include pregnancy within 3 months of death)
Due to _____
Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 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)

PHYSICIAN
Underline the cause to which death should be charged statistically.
108

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 *E. G. Rhoades* (M. D. or other) _____
Hermann Address _____ Date signed *4/10/48*

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

SUPPLEMENTARY

42425