

FILED JAN 5 1949

Registration District No. **211**

Primary Registration District No. **4406**

Registrar's No. **31**

1. PLACE OF DEATH:

(a) County **St. Clair**
(b) City or town **APPLETON CITY, MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ELLETTS HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Days**
In this community **74 yrs.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **ST. CLAIR**
(c) City or town **APPLETON CITY, MO.**
(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 _____

3. (a) PRINT FULL NAME **LOUISA MARIE BERN**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **no.**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, divorced **WIDOWED**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **May 16 1869**
(Month) (Day) (Year)

8. AGE: Years **78** Months **7** Days **3** If less than one day _____ hr. _____ min.

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

10. Usual occupation **DOMESTIC**

11. Industry or business _____

MOTHER FATHER { 12. Name **August Johannig-Mier**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Johanna Poliska**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **William Bern**

(b) Address **Rockville, Mo.**

17. (a) **BURIAL** (b) Date thereof **12 31 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **APPLETON CITY, MO.**

18. (a) Signature of funeral director: **Oscar Eckhoff**

(b) Address **APPLETON CITY, MO.**

19. (a) **Dec. 30-47** (b) **Mr. Olo Abrey**
(Date received local registrar) (Registrar's signature) **7 5 5**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **29**
year **1947** hour **6** minute **35 P.** M.

21. I hereby certify that I attended the deceased from **27 December**
1947 to **29 Dec** 19**47**;
that I last saw her alive on **29 Dec** 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Due to _____
Due to _____

Other conditions **bronchial asthma, allergy**
(Include pregnancy within 3 months of death)

Major findings: Of operations **438**
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 **Dr. Maurice M.D.** (M. D. or other) _____
Address **Appleton City, Mo.** Date signed **30 Dec 47**

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

12-47-2008
District Health Officer (In. 7)
District File Number 12-47-2008
Date Filed 1-3-48

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 Oscar Eckhoff
Licensed Embalmer No. 3942
P. O. Address Cyprian City, 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.