

Office of Vital Statistics  
**FILED APR 21 1948**

Registration District No. **316**

Primary Registration District No. **3060**

1. PLACE OF DEATH:  
(a) County **St. Francois**  
(b) City or town **Farmington**  
(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 **lifetime** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Francois**  
(c) City or town **Farmington**  
(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 **Elizabeth Johanna Kollmeyer**  
3. (b) If veteran, name war:  
3. (c) Social Security No.:

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **April** day **7**  
year **1948** hour **3** minute **20** p. M.

4. Sex **f** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **W**  
6. (b) Name of husband or wife **John J. Kollmeyer**  
6. (c) Age of husband or wife if alive **years**  
7. Birth date of deceased **Dec. 27, 1862**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 2** 1948 to **April 7** 1948  
that I last saw her alive on **April 3** 1948  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Cerebral hemorrhage**  
Duration **5 weeks**

8. AGE: Years **86** Months **3** Days **10**  
If less than one day hr. min.

Due to **Cerebral Arteriosclerosis**  
Duration **1 yr.**

9. Birthplace **near Farmington, Missouri**  
(City, town, or county) (State or foreign country)  
**housewife**

Due to **General Arteriosclerosis**  
Duration **4 yrs.**

10. Usual occupation:  
11. Industry or business:  
12. Name **Karl Best**  
13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Marie Ratch**  
15. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death):  
Major findings: **3H**  
Of operations:  
Of autopsy:

16. (a) Informant **Mrs. Jesse Simms**  
(b) Address **Farmington, Missouri**  
17. (a) **D** (Burial, cremation, or reinterment) (b) Date thereof **4-10-48**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Lutheran Cemetery**  
18. (a) Signature of funeral director **C. H. Cozean**  
(b) Address **Farmington, Missouri**  
19. (a) **4-10-48** (Date received local registrar) (b) **Ether Rudloff** (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) (Specify means of injury)  
Signature: **Geo. C. Weather** (M. D. or other)  
Address: **Farmington, Mo.** Date signed: **4-10-48**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 448-51

Date Filed 4-19-

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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. 4084

P. O. Address Farmington, 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.

Registration District No. 316

Primary Registration District No. 3060

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois

(c) City or town Farmington  
(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 Elizabeth J. Kallmeyer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1942 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 \_\_\_\_\_

Duration \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Dec 27  
(Month) (Day) (Year)

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

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

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)

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)

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 \_\_\_\_\_

SUPPLEMENTARY

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

S-13783

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