

No. 2  
-12-45  
-17-39  
X47070

FILED OCT 23 1948

State File No. ....

Registration District No. ....

Primary Registration District No. 3016

Registrar's No. 236

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
Specify whether

In this community 13 years  
years, months or days

3. (a) PRINT FULL NAME VIRGINIA HERZLING

3. (b) If veteran, name war WW

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

4. Sex Female race White 5. Color or White

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 June 29 1935  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>13</u>	<u>3</u>	<u>15</u>	hr. min.

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

10. Usual occupation School Girl

11. Industry or business

12. Name Conrad Herzling

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

14. Maiden name Mary Baumbach

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

16. (a) Informant Conrad Herzling

(b) Address Stalk, Missouri

17. (a) Buried (b) Date thereof Oct 18 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Boniface Cemetery

18. (a) Signature of funeral director Mela M. Strop

(b) Address Mela M. Strop

19. (a) 10-15-48 (b) R. P. Davis, Mo.  
(Date received local registrar) (Registrar or Emballer) (Licensed Emballer - Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage

(c) City or town Kaelztown  
(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 Oct day 15  
year 1948 hour 5 minute 40 A.M.

21. I hereby certify that I attended the deceased from Oct 8 to Oct 15, 1948  
that I last saw her alive on Oct 14, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Question Tuberculosis

Due to Supplementary cert part to be filed after autopsy

Other conditions         
(Include pregnancy within 3 months of death)

Major findings: Autopsy

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 J. A. Osmon (M. D. or other)       

Address Jefferson City, Mo. Date signed 12-15-48

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

MOTHER FATHER

RECEIVED  
STATE BOARD OF HEALTH  
OCT 23 1948

RECEIVED  
DIVISION HEALTH OFFICER No. 9,  
District and County  
Date Filed OCT 22 1948

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 *H. H. Strop*  
Licensed Embalmer No. *2924*  
P. O. Address *Meta 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. 77

Primary Registration District No. 2016

Registrar's No. 236 A

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town \_\_\_\_\_  
(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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Virginia Herzog  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month October day 15th  
 year 1948 hour 5 minute 10 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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: Broncho-pneumonia  
 Due to Multiple military lung abscesses

Duration

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 107

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 J. A. Osborn (M. D. or other) MD  
 Address City Mo Date signed 1-27-49

5. Color of \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

4. Sex \_\_\_\_\_ 6. (b) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: \_\_\_\_\_  
Month 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) 1-28-49 (b) R. P. Harris MD  
(Date received local registrar) (Registrar's signature)

Normal  
(Licensed Embalmer's Statement on Reverse Side)

SUTHERLAND REPORT

microscopic

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

X33897

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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.....

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.**