

FILED MAR 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7994

BIRTH NO. _____		REG. DIST. NO. 110		PRIMARY REG. DIST. NO. 5-425- Registrar's No. 2	
1. PLACE OF DEATH a. COUNTY FRANKLIN			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY FRANKLIN		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL BOEUF		c. LENGTH OF STAY (in this place) ALL	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL BOEUF		36
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) JOHANN b. (Middle) RUDOLPH c. (Last) JAEGER			4. DATE OF DEATH (Month) (Day) (Year) FEB 28 1949		
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH MAR 14 1921	9. AGE (In years last birthday) 27	10. IF UNDER 1 YEAR Months 11 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME JOHN JAEGER		13b. MOTHER'S MAIDEN NAME WILHELMIA SODMAN		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Geolph Wolff ADDRESS New Haven		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension with arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 years at least as 5 years
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION 4201				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 26 , 19 49 , to Feb 28 , 19 49 , that I last saw the deceased alive on Jan 9 , 19 49 , and that death occupied about 4 hours, from the causes and on the date stated above.					
23a. SIGNATURE B.P. Cismann (Degree or title) M.D.		23b. ADDRESS New Haven MO		23c. DATE SIGNED 3/1/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 3-3-49	24c. NAME OF CEMETERY OR CREMATORY NEW HAVEN	24d. LOCATION (City, town, or county) (State) NEW HAVEN MO		
DATE REC'D BY LOCAL REG. Mar 1st 49	REGISTRAR'S SIGNATURE Jeffie Bramm		25. FUNERAL DIRECTOR'S SIGNATURE W. B. Porter	ADDRESS San William & Co	

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

DATE FILLED 3/15/49
DISTANCE FROM STATE CAPITAL
DISTRICT HEALTH OFFICER NO. 2
RECEIVED

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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

Earl J. Foster

Signed.....

Student Embalmer

Licensed Embalmer No. 3385

P. O. Address *Heaven Ave*

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.