

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 14 1949

State File No. 34749

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. 293  |  | PRIMARY REG. DIST. NO. 6003   |  | Registrar's No. _____   |  |
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).    |  |   |  |
| a. COUNTY <i>Ralls</i>  |  | b. CITY (If outside corporate limits, write RURAL and give OR TOWN <i>Clayton</i> )   |  | c. LENGTH OF STAY (in this place) _____   |  | a. STATE <i>Missouri</i> b. COUNTY <i>Ralls</i>                 |  |
| c. CITY (If outside corporate limits, write RURAL and give township) <i>Summyside</i>   |  | d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Home</i>   |  | c. CITY (If outside corporate limits, write RURAL and give township) <i>Summyside</i>     |  | d. STREET ADDRESS (If rural, give location) <i>Rural</i>        |  |
| 3. NAME OF DECEASED   |  |   |  | 4. DATE OF DEATH  |  |   |  |
| a. (First) <i>Katharina</i>   |  | b. (Middle) _____   |  | c. (Last) <i>Leherbauer</i>   |  | 5. DATE OF DEATH (Month) (Day) (Year) <i>SEPT. 13. 1949</i>     |  |
| 5. SEX <i>Female</i>  |  | 6. COLOR OR RACE <i>White</i>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>                       |  | 8. DATE OF BIRTH <i>Aug. 19. 1897</i>                           |  |
| 9. AGE (In years last birthday) <i>72</i>   |  | 10. UNDER 1 YEAR Months <i>1</i> Days <i>25</i>   |  | 10. UNDER 24 HRS. Hours <i>1</i> Min. _____   |  | 9. AGE (In years last birthday) <i>72</i>                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Penn.</i>                                    |  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                      |  |
| 13a. FATHER'S NAME <i>John K. Kirchner</i>  |  | 13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>  |  | 14. NAME OF HUSBAND OR WIFE <i>Christian</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>   |  | 16. SOCIAL SECURITY NO. _____   |  | 17. INFORMANT'S SIGNATURE OR NAME <i>Leona Campbell</i> ADDRESS <i>B.H. New London Mo</i> |  |   |  |
| 18. CAUSE OF DEATH  |  | MEDICAL CERTIFICATION   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                |  |
| Enter only one cause per line for (a), (b), and (c)   |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Ca of stomach</i>   |  |   |  | _____   |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  | ANTECEDENT CAUSES   |  |   |  | _____   |  |
| _____   |  | Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.                         |  |   |  | _____   |  |
| _____   |  | DUE TO (b) _____  |  |   |  | _____   |  |
| _____   |  | DUE TO (c) _____  |  |   |  | _____   |  |
| _____   |  | II. OTHER SIGNIFICANT CONDITIONS  |  |   |  | _____   |  |
| _____   |  | Conditions contributing to the death but not related to the disease or condition causing death. <i>Secondary Metastases</i> |  |   |  | _____   |  |
| 19a. DATE OF OPERATION <i>7/8/49</i>  |  | 19b. MAJOR FINDINGS OF OPERATION <i>Ca of stomach</i>   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | _____   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/>  |  | 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 <i>6-1</i> , 19 <i>46</i> , to <i>9-13</i> , 19 <i>49</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at _____ m., from the causes and on the date stated above. |  |   |  |   |  |   |  |
| 23a. SIGNATURE <i>A. B. Henderson</i> (Degree or title)   |  |   |  | 23b. ADDRESS <i>1401 Blue Norwalk Mo</i>  |  | 23c. DATE SIGNED <i>9/14/49</i>                                 |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 24b. DATE <i>9-15-49</i>  |  | 24c. NAME OF CEMETERY OR CREMATORY <i>Cotnam Burial Park</i>                              |  | 24d. LOCATION (City, town, or county) <i>Hannibal Marion Mo</i> |  |
| DATE REC'D BY LOCAL REG. <i>Sept 16, 49</i>   |  | REGISTRAR'S SIGNATURE <i>H. J. Waters</i> 268   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <i>James Colson</i> ADDRESS <i>Hannibal Mo</i>           |  | _____   |  |

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District Health Officer No

District File Number 10-49

Date Filed OCT 10 1949

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 Michael J. O'Rourke

Signed Student Embalmer

Licensed Embalmer No. 3246

P. O. Address Hannibal 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.