

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33159**

BIRTH NO. _____ REG. DIST. NO. **119** PRIMARY REG. DIST. NO. **5442** Registrar's No. **9**

370
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) Richland Township		c. LENGTH OF STAY (In this place) 45 yrs.	
c. CITY (If outside corporate limits, write RURAL and give township) Rural Richland Township		d. STREET ADDRESS (If rural, give location) 13 Mi. W. of Hermann 0370	
d. FULL NAME OF HOSPITAL OR INSTITUTION 13 Mi. W. of Hermann			
3. NAME OF DECEASED (Type or Print) a. (First) Herman		b. (Middle) Henry	
c. (Last) Erfling		4. DATE OF DEATH (Month) (Day) (Year) 10 10 51	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 11, 1875
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Frederich Erfling	
13b. MOTHER'S MAIDEN NAME Charlotte Draer		14. NAME OF HUSBAND OR WIFE Bertha Erfling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Arthur Erfling, Hermann, Mo.		ADDRESS	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis ANTECEDENT CAUSES Morbid 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. Benign prostatic hypertrophy Hyper trophic arthritis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
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) (m.)		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 10-17 , 19 47 , to 10-10 , 19 51 , that I last saw the deceased alive on 10-10-51 , 19 51 , and that death occurred at 11:30 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Carol T. Shaw, M.D.		23b. ADDRESS Hermann, Mo.	
23c. DATE SIGNED 10-12-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/14/51	
24c. NAME OF CEMETERY OR CREMATORY St. John's Stolpe Cem.		24d. LOCATION (City, town, or county) (State) Hermann RFD Mo.	
DATE REC'D BY LOCAL REG. 10/12/51		REGISTRAR'S SIGNATURE W. M. ...	
FURNERAL DIRECTOR'S SIGNATURE W. M. ...		ADDRESS Hermann, Mo.	

File No. _____
DISTRICT HEALTH OFFICE No. 4

NOV - 8 1951

RECEIVED

MAR 28 1955

DEC 14 1954

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....

Hugo H. Blum

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.