

Registration District No. _____

347

Primary Registration District No. _____

5-481

1. PLACE OF DEATH:

(a) County Henry
 (b) City or town Rural - Bogard
(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)
 In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
Bogard Township
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Rosa Eller Eggers

3. (b) If veteran, name war _____
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Henry Eggers 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis County MO
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name John T. Shinc
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Ellen Swadlow
 15. Birthplace Mo. Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Eggers
 (b) Address Creston Mo.
 17. (a) Rural (b) Date thereof July 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wich Cemetery

18. (a) Signature of funeral director Robert Arnold
 (b) Address Creston Mo.
 19. (a) 7/26/1940 (b) _____
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 1
1940 to July 25 1940
 that I last saw her alive on July 25 1940
 and that death occurred on the date and how stated above.

Immediate cause of death Chronic myocarditis
C. D. Compensation
 Due to Portal Cirrhosis
 Due to _____

Duration

24

124

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 200
 Of autopsy 200

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? _____

312
 (Specify type of place) _____
 While at work? _____
 (b) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address Garden City Mo. Date July 26 1940

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

RECEIVED

District Health Officer No. 7,

District File Number 8-40-1190

Date Filed 8-12-40

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 Mr

~~3621~~, Registered Apprentice No. 3621
working under my personal supervision.

Signed

Robert Arnold

Licensed Embalmer No. 3621

P. O. Address Creghton 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25-292
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3485-

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

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Boyard
(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)

3. (a) PRINT FULL NAME

Rosa Ellean Eggera

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 21 If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-10-40 (b) Dr. J. R. Hancock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Henry
(c) City or town Boyard (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year _____ hour _____ minute _____ 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 _____

Duration

Due to _____

Due to _____

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 Geo. W. Buffell (M. D. or other) _____

Address Boyard Date signed _____

SUPPLEMENTAL

