No. 2
5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 8 1945
Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 2000

State File No. 2162
Registrar's No. 84

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wright
(c) City or town Mountain Grove
(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

3. (a) PRINT FULL NAME Henry Ferdinand Ellgeier
3. (b) If veteran, name war UNK
3. (c) Social Security No. UNK
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced widower
6. (b) Name of husband or wife UNK.
6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased July (Month) 9 (Day) 1864 (Year)
8. AGE: Years 80 Months 6 Days 19 If less than one day hr. min.
9. Birthplace St. Charles (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Harness Maker
11. Industry or business

MOTHER FATHER
12. Name Moritz Ellgeier
13. Birthplace UNK (City, town, or county) Germany (State or foreign country)
14. Maiden name Johanna Kempf
15. Birthplace UNK (City, town, or county) Germany (State or foreign country)

16. (a) Informant Owen B. Ellgeier
(b) Address Webster Groves Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Grove Mo.
18. (a) Signature of funeral director George Stapp
(b) Address Mt Grove Mo.
19. (a) 1-26-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 26
year 1945 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from Jan. 19, 1945 to Jan. 26, 1945 that I last saw him alive on Jan. 25, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to	
Due to ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Phillip Smith (M. D. or other) M.D.
Address Springfield Mo Date signed 1-26-45

(Licensed Embalmer's Statement on Reverse Side)

MAY 10 1945

NOV 16 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 Ogb Slone Jr.

Licensed Embalmer No. H 1576

P. O. Address Springfield

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.

No. 2B
—3-45
I X43880

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

2nd Query

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2162

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 84

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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)

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

3. (a) PRINT FULL NAME Henry J. Allgeier
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased July 9 (Month) (Day) (Year)

8. AGE: Years 80 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)
10. Usual occupation
11. Industry or Business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Uraemia	
Due to Chronic nephritis	
Other conditions (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations
Of autopsy 3/6

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

S-2162