

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11317
Do not use this space.

REC'D APR 19 1939

1. PLACE OF DEATH *2*

(a) County *Rainette* Registration District No. *460*

(b) Township *Davis* Primary Registration District No. *A274*

(c) City *Raymondville* (d) Street No. _____ St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Claus Dohrmann*

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Anna Belle Dohrmann*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 15 1862*

7. AGE YEARS *76* MONTHS *8* DAYS *18* IF LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired*

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-2-1939*

22. I HEREBY CERTIFY, That I attended deceased from *3-2-1939* to *3-2-1939*

I last saw _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *11:30 a.m.*

The principal cause of death and related causes of importance were as follows:

Pneumonia lobar (left base)
Coronary Con
Myocarditis Chronic
Endocarditis Chronic

Other contributory causes of importance: *100*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

13. NAME *Friedrich Dohrmann*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Muhauw*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Mrs. Dohrmann Raymondville Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *City Cem* DATE *3-5-39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Koepfer & Meiners Raymondville Mo*

20. FILED *April 20 1939* *Raymond Webb* Local Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

(Signed) *Robert*, M. D. (Address) *Odessa Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 81
District File Number 4/4/39
Date Filed

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 *W. Meinershagen*
Licensed Embalmer No. 1095

P. O. Address.....

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.