

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1064
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 1002 Registered No. 49
 (c) City Kansas City, Mo. Street No. St. Luke's Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 8 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Butler Missouri St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Erman
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 12 1894
 7. AGE YEARS 45 MONTHS 7 DAYS 24 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) O'Fallon Mo.

13. NAME George M. Litor

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) O'Fallon Mo.

15. MAIDEN NAME Caroline Halter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) O'Fallon Mo.

17. INFORMANT (ADDRESS) William F Erman Butler Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St Louis Mo DATE Jan 6 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carlton H. K. Butler Mo.
M. M. Browne
 Local Registrar.

20. FILED Jan. 5 1940

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-5 1940

22. I HEREBY CERTIFY, That I attended deceased from 12-28 1899 to 1-5 1940

I last saw her alive on 1-4 1940 Death is said to have occurred on the date stated above, at 2:45 A. M.

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

Subacute bacterial endocarditis
9/10
 Other contributory causes of importance:

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
 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? No.
 If so, specify
 (Signed) R. E. DAVIS, M. D.
 (Address)

NOV 6 1946

OCT 19 1945

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..... *B. Denton Lisle*
Licensed Embalmer No. *4123*
P. O. Address *Butler, 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 1064

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson
(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
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(d) Street No.
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME

Agnes E. Ermann

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

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years 45 Months 7 Days 24

If less than one year

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) (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) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Jan day 5 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from
that I last saw h. alive on
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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 P. C. Davis (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

