

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

11570
 Do not use this space.

1. PLACE OF DEATH **APR 23 1940**

(a) County Linn Registration District No. 496

(b) Township Brookfield Primary Registration District No. 3025 Registered No. 18

(c) City Brookfield (d) Street No. McFarmer 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Margret Jane Zahner

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo Zahner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23 1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>49</u>	<u>5</u>	<u>15</u>	

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) Mendon Mo.

FATHER

13. NAME David Hotchkiss

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York state

MOTHER

15. MAIDEN NAME Anna Hughes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Mrs Wm. Osterman
Salisbury Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Indian Grove DATE Mar. 11/1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) S. L. Leopard
Mendon Mo.

20. FILED Apr 1 1940 not trace Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 9/1940 19

22. I HEREBY CERTIFY, That I attended deceased from 2/22/40, 1940, to 3-9-40, 1940. I last saw him alive on 3/9, 1940. Death is said to have occurred on the date stated above, at 7:30 A.M.

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

Pertussis Date of onset 10da

ruptured aorta 10da

Gas Blood 10da

Other contributory causes of importance:

Inc. Infected G. Blood 10yo.

Name of operation Daniel G. Bell Date of 2-22-40

What test confirmed diagnosis? g. c. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? 0 Date of injury 0, 1940

Where did injury occur? 0 (Specify city or town, county, and State)

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

Manner of injury 0

Nature of injury 0

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify not trace

(Signed) J. W. Osterman, M. D.

Address Brookfield Mo

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RECEIVED
District Health Officer No. 11,
District File Number 440-475
Date Filed APR 9 1949

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 S. L. Shepard

Licensed Embalmer No. 3970

P. O. Address Mendon 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. 11570
Registrar's No. 18

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 496

Primary Registration District No. 3025-

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

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 Margaret Jane Zahner
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 wid
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 49 Months 5 Days 15 If less than one day _____ hr _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Mar day 9
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis
ruptured - abscess of gall bladder

Due to No stone - chronic inflammation condition
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 187
Of operations _____
Of autopsy _____

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)
Means of injury _____

23. Signature J. M. Layman (M. D. or other) _____
Address Brookfield Mo Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

11570 (1940)