

APR 23 1940

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

Do not use this space.

12144

1. PLACE OF DEATH

County Randolph Registration District No. 735
Township Moberly Primary Registration District No. 3034
City 512 Moberly (No. 0) St. _____ Ward _____

File No. _____
Registered No. 69

2. FULL NAME

(a) Residence, No. Woodland Hospital Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 9. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emil Fuenfhausen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22-1912

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
27 8 28

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housewife
9. Industry or business in which work was done, as silk mill, 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) Mo 0

FATHER
13. NAME Gerald Gortz
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 1

MOTHER
15. MAIDEN NAME Anna Bree
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

17. INFORMANT (ADDRESS) Wm Gortz
Salisbury Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Salisbury DATE 3/23 1940

19. UNDERTAKER (ADDRESS) Bro B. Winkelmeier
Salisbury Mo

20. FILED Mar 20 1940 Seah William Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 20 1940

22. I HEREBY CERTIFY, That I attended deceased from March 13 1940, to March 20 1940
I last saw h.s. alive on March 20 1940 Death is said to have occurred on the date stated above, at 9:40 P.m.
The principal cause of death and related causes of importance were as follows:

Cyst of right ovary
12 1/2
Other contributory causes of importance: Eucobolium, March 19, 1940.

Date of onset 8 weeks
Symptom 6 weeks

Name of operation { Right ovary and appendix removed } Date of March 15/40
What test confirmed diagnosis? _____ Was there an autopsy? _____

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? No
If so, specify _____
(Signed) R. D. Streetor M. D.
995 (Address) Moberly, 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.

This body embalming by
Geo B Winkelman

RECEIVED

District Health Officer No. 10

District File Number 4-40-891

Date Filed APR 16 1940

Geo B Winkelman

License # 2125

Salisbury
Mo

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12147

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735

Primary Registration District No. 3024

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Manchester
(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 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton

(c) City or town Salisbury
(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.

3. (a) PRINT FULL NAME Leontucile Fremhausen

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

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

4. Sex F 5. Color or race W 6. (a) Single in widowed, married, divorced _____

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)

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 _____

8. AGE: Years 27 Months 8 Days 28 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation _____

Major findings: _____ Of operations _____

11. Industry or business _____

12. Name _____

Of autopsy _____

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

14. Maiden name _____

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

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? _____

16. (a) Informant _____ (b) Address _____

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

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

23. Signature R. D. Street (M. D. or other) _____

Address Manchester Mo Date signed _____

18. (a) Signature of funeral director _____

(b) Address _____

(9) (a) Mar 20-40 (b) Jean Williams (Date received local registrar) (Registrar's signature)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

1940

S-12144