

11-10-39
5-17-39
PI X21402

Registration District No. 799 III 17 1940 Primary Registration District No. 6037 B Registrar's No. 29

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

1. PLACE OF DEATH
(a) County Lamine
(b) City or town Rural - Cambridge
(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 60 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME Riska Jakob Wilhelm
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race White 6. (a) Single-widowed, divorced, widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June-22-1859
(Month) (Day) (Year)

8. AGE: Years _____ Months 11 Days 10 If less than one day _____ hr. _____ min.
82 8 11 10

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

10. Usual occupation House wife

11. Industry or business _____
12. Name Karl W Jakob
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Donat Jakob
15. Birthplace know
(City, town, or county) (State or foreign country)

16. (a) Informant RH Williams
(b) Address Slater, Mo

17. (a) Burial (b) Date thereof June 4-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial State City Cemetery

18. (a) Signature of funeral director Wm. J. Salpe
(b) Address Slater, Mo

19. (a) 6-3-40 (b) Wm. J. Salpe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lamine
(c) City or town Rural
(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.? 77 years years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day _____ year 1940 hour _____ minute 30 A.M.
21. I hereby certify that I attended the deceased from _____ 1938 to June 2 1940
that I last saw her alive on May 29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration years

Due to Generalized Arteriosclerosis ?

Due to Essential Hypertension ?

Other conditions _____ (Include pregnancy within 3 months of death) 131

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____ years
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 W. A. McBurney (M. D. or other) _____
Address Slater, Mo. Date signed 6-3-40

RECEIVED
District Health Officer No. 8
District File Number 4-13-10
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

working under my personal supervision.

Registered Apprentice No.

Signed *E Jones*

Licensed Embalmer No. *143*

P. O. Address *State*

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. 22938

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 799

Primary Registration District No. 003B

Registrar's No. 29

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

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Cambridge, T.C.
(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 Ricka Zablutsky

3. (b) If veteran, name war.....

3. (c) Social Security No. 00164

4. Sex 7

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	Months	Days	If less than one day
<u>82</u>	<u>11</u>	<u>10</u> min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER {

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..... day.....
year..... hour..... minute..... M.

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.

Duration

Due to.....

Due to.....

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

23. Signature Ch. de Burney (M. D. or other)
Address State Date signed.....

SUPPLEMENTARY

S-22938