

Registration District No. 875

Primary Registration District No. 6160

1. PLACE OF DEATH:

(a) County Vermon  
(b) City or town Nevada  
(c) Name of hospital or institution:  
Rural - Center Twp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 56 yrs (Specify whether years, months or days)

8. (a) PRINT FULL NAME William Autenmuth

3. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louise Autenmuth 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased June 15 1854 (Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 11 If less than one day hr. min.

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

10. Usual occupation Retail Merchant

11. Industry or business Retail Business

12. Name William Autenmuth

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

14. Maiden name Anna Schwarz

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

16. (a) Informant August Autenmuth

(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof 7/28/40 (Month) (Day) (Year)

(c) Place: burial or cremation Deerpark Park

18. (a) Signature of funeral director Frank Weibinger

(b) Address Nevada, Mo

19. (a) 7-29-40 (Date received local registrar) (b) Allen V. Zapp (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vermon  
(c) City or town Nevada, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. R 7. N. #3 (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 69 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1940 hour 9:00 minute 10: A.M.

21. I hereby certify that I attended the deceased from May 15 1940 to July 26 1940 that I last saw him alive on July 26 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death) None

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? 7 M 5  
While at work? (Specify type of place) (e) Means of injury

23. Signature Dr. Krueger (M. D. or other) 1  
Address Nevada, Mo Date signed 7-27-40

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

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RECEIVED

District Health Officer No. 7;

District File Number 8-40-1143

Date Filed 8-9-40

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**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.....

*Mark Leiberger*

Licensed Embalmer No. 2636

P. O. Address Nevada, M

**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. 265-26  
Registrar's No. 184

Registration District No. 875

Primary Registration District No. 6160

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Center T. P.  
(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

3. (a) PRINT FULL NAME Wm. AUTENRIETH

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

4. Sex m 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 \_\_\_\_\_ years

7. Birth date of deceased. \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 86 Months 1 Days 11 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 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 \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
(Burial, cremation, or removal) (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 7-29-42 (b) Allen V. Hays  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 7 day 26  
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.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 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)  
a. (e) Means of injury \_\_\_\_\_

23. Signature E. R. King (M. D. or other) \_\_\_\_\_  
Address St. Louis Date signed \_\_\_\_\_

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

SUPPLEMENTAL

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