

No. 2  
5-17-39  
I X26390

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10629

Registration District No. 303 Primary Registration District No. 4182 Registrar's No.

37  
1  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Gasconade  
(b) City or town Hermann  
(c) Name of hospital or institution 1  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution (Specify whether)  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State German Mo (b) County Gase. 37  
(c) City or town (If outside city or town limits, write "RURAL") 1  
(d) Street No. (If rural, give location) 0  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME ELIZABETH ANNA TRACY  
(b) If veteran, name war  
(c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 3/31/41 day 15  
year hour 3:45 minute A M.  
21. I hereby certify that I attended the deceased from 3-10 1941 to 3-31 1941;  
that I last saw her alive on 3-31 1941;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced 1 2  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased: Jew 14 1862  
(Month) (Day) (Year)

Immediate cause of death Mitral Insufficiency Duration  
Due to  
Due to

8. AGE: Years 79 Months 2 Days 27 If less than one day hr. min.

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.

9. Birthplace Stolpe, Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER {  
12. Name Geo Bauer  
13. Birthplace Switzerland 5 (City, town, or county) (State or foreign country)  
14. Maiden name Eva Koeller  
15. Birthplace Switzerland 5 (City, town, or county) (State or foreign country)

16. (a) Informant Phillip Bauer

(b) Address Hermann Mo

17. (a) Burial (b) Date thereof 4/27/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hermann

18. (a) Signature of funeral director R. P. Hediger  
(b) Address Hermann Mo

19. (a) 4-1-41 (b) Anna K. Rickhoff  
(Date received local registrar) (Registrar's signature)

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 Howard Workman (M. D. or other) 0  
Address Hermann Date signed 4-1-41

**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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed J. Ruediger  
Licensed Embalmer No. 2044  
P. O. Address Herman 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, fact should be so stated above.**

No. 2  
1-4-41  
1-17-39  
PI 426390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10629

Registration District No. 303

Primary Registration District No. 4182

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Vermann  
(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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elizabeth Anna Tracy  
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 widowed  
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 79 Months 2 Days 27  
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 \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
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) 6-9-41 (b) Anna K. Rickhoff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31  
year 1941 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 \_\_\_\_\_

Duration \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

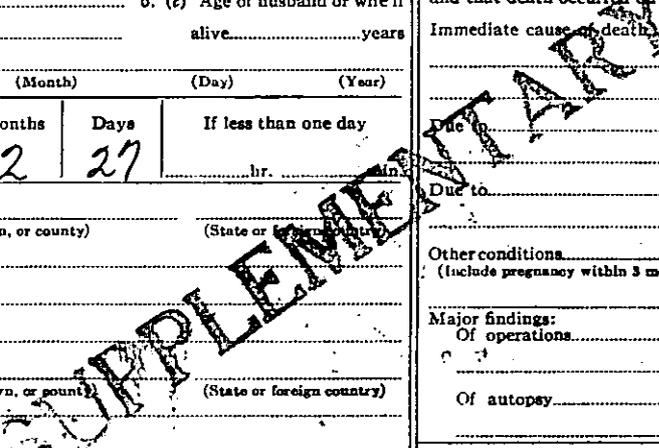
PHYSICIAN \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Howard Warkman (M.D. or other) \_\_\_\_\_  
Address Vermann mo Date signed \_\_\_\_\_

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



1941  
S-10629

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**