DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1942

Registration District No. 3047

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3018

State File No. 6756

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Clinic (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Montrose Mo (If outside city or town limits, write "RURAL")
(d) Street No. Rural Deepwater Twp. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Louise Fonkie
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife
6. (c) Age of husband ~~or wife~~ if alive 40 years
7. Birth date of deceased March (Month) 10 (Day) 1902 (Year)

8. AGE: Years 39 | Months 11 | Days | If less than one day ... hr. ... min.

9. Birthplace Missouri (City, town, or county) U (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Sophinke
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Clara Albright
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Alvin Fonkie
(b) Address Montrose Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Montrose Mo
18. (a) Signature of funeral director Welling Bros
(b) Address Montrose Mo
19. (a) Feb. 11-1942 (Date received local registrar) (b) Georgia Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 10 day 1942. year 1942 hour 600 minute P M.
21. I hereby certify that I attended the deceased from 1938. 19.. to Feb. 10, 1942 that I last saw h. alive on Feb. 10. 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Shock	4 hrs.
Due to Post operative	
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 Joseph B. Mills (M. D. or other) MD
Address Albany, Mo. Date signed 2-11-42

1069

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 3-42-176
Date Filed 3-4-42

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 ..... on the 10th day of Feb 1942, Registered Apprentice No. ..... working under my personal supervision.

Signed Frank Lee

Licensed Embalmer No. 1099

P. O. Address Appleton City 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6756

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(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 years, months or days)
In this community

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 Louise Honkie
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 10 1900 (Month) (Day) (Year)

8. AGE: Years 39 Months 16 Days 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

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 h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Post Operative
Due to
13 days
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Prolapse of the uterus
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature Joseph B Quill (M. D. or other) MD
Address Clinton Date signed Mo

SUPPLEMENTARY