

2-43  
-17-39  
X35697

FILED FEB 9 1947

Registration District No. 207

Primary Registration District No. 4497

Registrar's No. 20

1. PLACE OF DEATH:  
 (a) County Shelby  
 (b) City or town Clarence Mo  
(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 1  
(Specify whether  
 In this community 4 years  
years, months or days)

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

3. (a) PRINT FULL NAME Maranta Jane Sengwald  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan day 23  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_  
 \_\_\_\_\_, 19\_\_\_\_, to Jan 23, 19\_\_\_\_;  
 that I last saw her alive on Jan 20, 1944  
 and that death occurred on the date and hour stated above.

4. Sex F. m. 5. Color or race Dr. 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife Ernst Sengwald 6. (c) Age of husband or wife if alive yes years \_\_\_\_\_  
 7. Birth date of deceased 9/1/1967  
(Month) (Day) (Year)

Immediate cause of death:  
 Due to Broncho Pneumonia  
 Due to Influenza  
 Other conditions (Include pregnancy within 3 months of death) 330  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
76 ✓ 16 hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Nurse

11. Industry or business \_\_\_\_\_  
 12. Name Edward M. Coffey  
 13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
 14. Maiden name Pauline Smith  
 15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ernst Sengwald  
 (b) Address Clarence Mo  
 17. (a) Burial (b) Date thereof 1-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Evangelical cemetery  
 18. (a) Signature of funeral director Ed Hooper  
 (b) Address Clarence Mo  
 19. (a) 1/23/44 (b) Madge Good  
(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 Frank Roy (M. D. or other) \_\_\_\_\_  
 Address Clarence, Mo Date signed 1/28/44

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-226

Date Filed FEB 8 1944

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..... *E. E. Napp*.....

Licensed Embalmer No. 4260.....

P. O. Address..... *Salamanca, Pa.*.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Clarence  
(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 4 yr  
years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Maranda G. Guenard

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 7 years 11 months 26 days

7. Birth date of deceased Nov. 9 1886  
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 26 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) Feb. 4 44 (b) Madge Spook  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 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 \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

4036