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24636

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 21 1944
Registration District No.

Primary Registration District No. 4190

Registrar's No. 90

237
60

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

1. PLACE OF DEATH: *Gasconade*
 (a) County.....
 (b) City or town..... *Bland Mo*
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: *Rolla Mo. Hospital*
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *2 weeks*
(Specify whether
 In this community *all his life*
years, months or days)

3. (a) PRINT FULL NAME *AUGUST DAUEL*
 3. (b) If veteran, name war..... *no*
 3. (c) Social Security No. *none*

4. Sex *Male* 5. Color or race *White*
 6. (a) Single, widowed, married, divorced, *widowed*
 6. (b) Name of husband or wife *EMMA* 6. (c) Age of husband or wife if alive *dead* years
 7. Birth date of deceased *June 29 1856*
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<i>85</i>	<i>0</i>	<i>1</i>hr.min.

9. Birthplace *Fenersville Mo.*
(City, town, or county) (State or foreign country)
 10. Usual occupation *Retired farmer*
 11. Industry or business.....

MOTHER FATHER {
 12. Name *Fritz Dauel* #
 13. Birthplace *Germany* #
(City, town, or county) (State or foreign country)
 14. Maiden name *Kueger* #
 15. Birthplace *Germany* #
(City, town, or county) (State or foreign country)

16. (a) Informant *Rufus Schneider*
 (b) Address *Bland Mo*
 17. (a) *burial* (b) Date thereof *July 2 1944*
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation *Old Bland Cem*

18. (a) Signature of funeral director *Samuel Funn*
 (b) Address *Bland Mo*
 19. (a) *July 1st, 1944* (b) *Myrtle M. Wenkel*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Mo.* (b) County *Gasconade* ³⁷
 (c) City or town *Bland Mo.*
(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.? *0* years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *30*
 year *1944* hour *4* minute *9* A. M.
 21. I hereby certify that I attended the deceased from *June 15*, 19*44* to *June 30* 19*44*
 that I last saw him alive on *June 15*, 19*44*
 and that death occurred on the date and hour stated above.

Immediate cause of death *Operation for strangulated*
 Due to *inguinal Hernia*
 Due to.....

Other conditions *Old age*
(Include pregnancy within 3 months of death)

Major findings:
 Of operations *122*
 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 *fall*
 23. Signature *C. A. Bunge* (M.D. or other)
 Address *Bland Mo* Date signed *6-30*

1287

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-20-44

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. me

working under my personal supervision.

Signed..... Robert M Murray

Licensed Embalmer No. 3749

P. O. Address. Owensville 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.