

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1587

FILED FEB 13 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 3002

Registrar's No. 6

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Audrain Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months
(Specify whether years, months or days) 0
In this community 6 years
(Specify whether years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Audrain
(c) City or town Mexico
(If outside city or town limits, write "RURAL") 2
(d) Street No. 729 S. Jefferson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Emma Forman
3. (b) If veteran, name war No 3. (c) Social Security No. No
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Aug. 4, 1864
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 6
year 1945 hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from Nov 9, 1944 to Jan 6, 1945
that I last saw h. aw alive on Jan 6, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
80 5 2 _____ hr. _____ min.

Immediate cause of death Fracture left hip
Due to _____
Due to _____

9. Birthplace Macon, Missouri
(City, town, or county) (State or foreign country)

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation Widow

11. Industry or business _____

12. Name Fredrick Jurgenson
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Broel
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Maria Forman
(b) Address Mexico, Mo.

17. (a) Burial (b) Date thereof 1/8/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director Chris Amundson
(b) Address Mexico, Missouri

19. (a) 1/7/45 (b) Margaret Mackie
(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 0 MA

23. Signature Frank Jolley (M. D. or other) MA
Address Mexico, Mo. Date signed 1/7/45

MOTHER FATHER

Duration
Physician
Underline the cause to which death should be charged statistically.

1074

MAR 10 1956

RECEIVED
District Health Officer No. 10
District File Number 2-45-280
Date Filed FEB 11 1945

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 *Chris Amold*
Licensed Embalmer No. 3569
P. O. Address Mexico, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 6

1. PLACE OF DEATH:
 (a) County Audrain
 (b) City or town Mexico
(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

3. (a) PRINT FULL NAME Emma Forman
 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 w
 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 80 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

MOTHER FATHER
 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) _____ (b) _____
(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 _____ day _____
 year 1945 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 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)

ADDITIONAL SUPPLEMENTARY INFORMATION TESTED
 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) accident
 (b) Date of occurrence Nov 9 1944
 (c) Where did injury occur? Home
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place)
 (c) Means of injury fall on floor
 23. Signature Frank Jolley (M.D. or other) MD
 Address Mexico Mo Date signed 2/16/45

SUPPLEMENTARY

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

1587