No. 2
I—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 14 1945

walker

State File No. 24073

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 154

1. PLACE OF DEATH:
(a) County Henry Co
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Clinton General 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. In this community 5. Month (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry 42
(c) City or town Clinton 0 (If outside city or town limits, write "RURAL")
(d) Street No. Rural 0 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Miss Katherine Drach
3. (b) If veteran, name war —
3. (c) Social Security No.

4. Sex Fe 1
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 12 26 1854 (Month) (Day) (Year)

8. AGE: Years 90 Months 7 Days 1 If less than one day hr. min.

9. Birthplace Pittsburg Penn 1 (City, town, or county) (State or foreign country)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name John Drach 4
13. Birthplace Germany 7 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace Germany 4 (City, town, or county) (State or foreign country)

16. (a) Informant Thad Taylor
(b) Address Clinton Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation Englewood
18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo
19. (a) July 31 (Date received local registrar) (b) Myrtle Brownlee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1945 hour 9 30 minute P M.

21. I hereby certify that I attended the deceased from April 15, 1945, to July 31, 1945; that I last saw her alive on July 31, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial pneumonia	5 da
Due to Fractured hip & Confinement to bed	3 mo
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) 43
(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 G. I. Walker (M. D. or other)
Address Clinton Mo Date signed 7-31-45

1391

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Dist. ... Health Officer No. 7
Date ... 7-43 -- 814
Lic. ... 8-13-43
Date Filed ...

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 Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton 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
SM—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 154

SUPPLEMENTARY

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
In this community (Specify whether 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 Katherine Drach
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 30 1855 (Month) (Day) (Year)
8. AGE: Years 90 Months 2 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Penn (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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 May Day 31
year 1945 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.

	Duration
Immediate cause of death Hypostatic pneumonia	10 da
Due to fractured hip.	10 wks
Due to	

Other conditions (Include pregnancy within 3 months of death)
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 May
(c) Where did injury occur? Clinton (City or town) Henry (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at Farm home fell broke femur (Specify type of place)
While at work? no (e) Means of injury
23. Signature G. L. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 8-20-45

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

SEP - 6 1945

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