

No. 2
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-17-39
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33689

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 5

FILED NOV 12 1945
Registration District No. _____

Primary Registration District No. 5429

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Rural - Lyon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Her residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
Lifetime (Specify whether)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1/2 Mile East of Stonyhill, Mo
(If rural, give location) _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME MINNIE LOUISA FLEER
3. (b) If veteran, name war No
3. (c) Social Security No. None

20. DATE OF DEATH: Month October, day 13th
year 1945 hour 10 minute 00A, M.

4. Sex Female 5. Color or race White
6. (a) Single, ~~married~~ single

21. I hereby certify that I attended the deceased from May 12 1945 to Oct. 13 1945
that I last saw her alive on Oct. 12 1945
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife 0
6. (c) Age of husband or wife if alive 0 years

Immediate cause of death: Carcinoma of Right Breast with metastases to abdomen Duration 2 years

7. Birth date of deceased: February 26th 1881
(Month) (Day) (Year)

Due to _____
Due to _____

8. AGE: Years 64 Months 7 Days 17
If less than one day _____ hr. _____ min.

Other conditions: _____
(Include pregnancy within 3 months of death)

9. Birthplace: Franklin County Missouri
(City, town, or county) (State or foreign country)

Major findings: no operation
Of operations _____
Of autopsy no autopsy
Underline the cause to which death should be charged statistically.

10. Usual occupation Housekeeping
11. Industry or business Housekeeper
12. Name Henry John Fleer
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Christina Rohlfing
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. August Fleer
(b) Address Stonyhill, Missouri

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 10/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Stonyhill, Missouri

(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? _____

18. (a) Signature of funeral director Paul H. Blumer
(b) Address Berger Missouri

While at work _____ (Specify type of place)
(c) Means of injury _____
23. Signature B.P. Eisenmann (M. D. or other) M.D.
Address New Haven, Mo. Date signed 10/13/45

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

1558

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 11-2-45

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.

Registration District No. 112

Primary Registration District No. 5429

1. PLACE OF DEATH
(a) County Franklin
(b) City or town _____
(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 Minnie L. Fleer
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. 26 (Month) (Day) (Year)

8. AGE: Years 64 Months ? Days _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-15-45 (b) [Signature] (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 _____ at _____
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ at _____ 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)

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

Major findings:
Of operations _____
Of autopsy _____

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

33689