

No. 2  
3-13  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9914

FILED APR 10 1946

State File No. \_\_\_\_\_

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 31

1. PLACE OF DEATH

(a) County JOHNSON  
(b) City or town WARRENSBURG  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Warrensburg Hosp. & Clinic, Inc.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks 0  
(Specify whether  
In this community 3 weeks  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE 54  
(c) City or town CONCORDIA  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME SOPHIE MARTHA WEBER

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

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

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

7. Birth date of deceased OCT 15 1867  
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace CONCORDIA MO 11  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business Home

12. Name DETRICH KUESTER

13. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

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

16. (a) Informant NORBERT BASTIAN

(b) Address KANSAS CITY MO 948 HOMER ST

17. (a) Burial (b) Date thereof MAR 10 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation METHODIST CEMETERY

18. (e) Signature of funeral director F. S. JAMES

(b) Address CONCORDIA MO

19. (a) MAR 5 1946 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 8  
year 46 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from Feb 46  
19 to March 8 - 1946

that I last saw him alive on 3-8-46  
and that death occurred on the date and hour stated above.

Immediate cause of death Chn Myocarditis ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: Of operations 934

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 R. J. James (M. D. or other) \_\_\_\_\_

Address Warrensburg MO Date signed 3-9-46

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

**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed E. S. James

Licensed Embalmer No. 2058

P. O. Address Conordia 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. 164 Primary Registration District No. 3022

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

1. PLACE OF DEATH:  
 (a) County Johnson  
 (b) City or town Warrensburg  
 (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 (Specify whether \_\_\_\_\_)  
 3. (a) PRINT FULL NAME Sophie M. Weber  
 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 wid  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
 7. Birth date of deceased: Oct 15 1906  
 (Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo  
 10. Usual occupation Home  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER

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. (c) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (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 Mar year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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) \_\_\_\_\_  
 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 \_\_\_\_\_

SUPPLEMENTARY

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

9914