

No. 2
5-17-39
57823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 31 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41157

State File No. _____

Registration District No. 172

Primary Registration District No. 4271

Registrar's No. 57

1. PLACE OF DEATH:
 (a) County Lafayette
 (b) City or town Alma, Missouri
(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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette **54**
 (c) City or town Alma, Missouri **0**
(If outside city or town limits, write "RURAL") **0**
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____ **(1)**

3. (a) PRINT FULL NAME Christina Sophia Becker.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced. wid

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

7. Birth date of deceased: January 21, 1853
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>10</u>	<u>16</u>	hr. _____ min. _____

9. Birthplace Hanover, Germany. **4**
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Geo. Duensing, **4**
13. Birthplace Germany **4**
(City, town, or county) (State or foreign country)

14. Maiden name Marie Schwabe,
15. Birthplace Germany **4**
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. H. Meyer,
(b) Address Kansas City, Missouri.

17. (a) Burial Burial (b) Date thereof 12/10/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
Coplen, Mo.

18. (a) Signature of funeral director Alma W. Fischer
(b) Address _____

19. (a) Dec 13 - 1946 (b) Clayton W. Landrum
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7th,
year 1946 hour eight minute 35 p.m.

21. I hereby certify that I attended the deceased from 11-1-
1944 to 12-7- 1946
that I last saw her alive on 12-7- 1946
and that death occurred on the date and hour stated above.

Immediate cause of death old age

Due to _____
Due to _____

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

Major findings: 162B
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?
(Specify type of place)

While at work? _____ (e) Means of injury 0
23. Signature J. W. Fischer (M. D. or other) _____
Address Alma, Mo. Date signed 12-9-46

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

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

12-30-46

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 _____

Alfred A. Brewer

Licensed Embalmer No. 2696.

P. O. Address Alma, Missouri.

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. 172

Primary Registration District No. 4271

1. PLACE OF DEATH:

(a) County Safayette
(b) City or town Alma
(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

Christina S Becker

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 widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 2 (Month) 1943 (Year)

8. AGE:

Years 93

Months _____

Days _____

If less than one day _____ hr. _____ min.

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

Germany

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) _____ (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) Clayton H. Landrum (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 _____, 1943 year _____, 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 _____

Duration _____

Due to _____

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) _____

(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

MOTHER FATHER

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A REVERSE COPY

41157