

S. No. 2  
1-5-43  
5-17-39  
1-2-7823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 28 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **1967**

Registration District No. **240**

Primary Registration District No. **43-9-2-5884**

Registrar's No. **2**

**1. PLACE OF DEATH:**

(a) County **Osage**  
(b) City or town **Freeburg Mo. R.D.**  
(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 **Yrs.** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Osage 76**  
(c) City or town **Freeburg Mo**  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME Alphonse Ben Bax**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **M**  
6. (b) Name of husband or wife **Teresa Grellner** 6. (c) Age of husband or wife if alive **52** years  
7. Birth date of deceased **Jan 18 1897**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**49 11 28** hr. min.

9. Birthplace **St. Elizabeth Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Franc H. Bax**  
13. Birthplace **St. Elizabeth Mo**  
14. Maiden name **Johanna Drueding**  
15. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. A. B. Bax**  
(b) Address **Freeburg Mo**  
17. (a) **Burial** (b) Date thereof **Jan 20 47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Rich Fountain Mo**  
18. (a) Signature of funeral director **Clyde Maston**  
(b) Address **Freeburg Mo**  
19. (a) **1-19-47** (b) **Mrs. H. H. Moore**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **January** day **16**  
year **1947** hour **10:00** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **January 14 1947** to **January 16 1947**  
that I last saw him alive on **January 16 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**  
Due to **Left Coronary Artery (Bilateral)** **10 days**  
Due to **Chronic Bronchial Asthma** **Chronic**

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **2**  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **D. C. F. Puelbert** (M.D. or other) **20**  
Address **Tipton Mo** Date signed **1-19-47**

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

MAR 1 9 1947  
27 1947

Date Filed JAN 27 1947

District File Number

District Health Officer No. 9,

RC 5-1-0  
JAN 27 1947  
ADM

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 *Vernon M. Morton*

Licensed Embalmer No. *4125*

P. O. Address *Lynn*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 260

Primary Registration District No. 5884

Registrar's No. ....

1. PLACE OF DEATH:

(a) County: Osage

(b) City or town: Rural  
(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 years, months or days)

3. (a) PRINT FULL NAME: Alphonse B. Box

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex: m

5. Color or race: w

6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife: \_\_\_\_\_

6. (c) Age of husband or wife if alive: \_\_\_\_\_

7. Birth date of deceased: \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 49 Months 4 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation: \_\_\_\_\_

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. (a) \_\_\_\_\_ (b) Date thereof: \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation: \_\_\_\_\_

18. (a) Signature of funeral director: Clyde Morton

(b) Address: Linn, Mo

19. (a) 1-19-47 (b) Mrs. H. H. Moore  
(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 \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ 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) (c) Means of injury \_\_\_\_\_

23. Signature: \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address: \_\_\_\_\_ Date signed: \_\_\_\_\_

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

SUPPLEMENTARY

S-1967