

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

Rev. 5-17-39 I X10311

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED OCT 29 1947

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 238

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCombs Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 327 Hazard
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Adahne E. Tencke
(b) If veteran, name war ✓
(c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct, day 22, year 1947 hour 7 minute 30 A. M.

4. Sex Female 5. Color or race W
6. (a) Name of husband or wife none
6. (b) Single, widowed, married, divorced single
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 12 25-1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 14, 1947 to Oct 22, 1947
that I last saw her alive on Oct. 22, 1947
and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 9 Days 27
If less than one day hr. _____ min. _____

Immediate cause of death Hyphostatic Pneumonia
Due to Senility & Senile dementia
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Major findings: III
Of operations _____
Of autopsy _____

10. Usual occupation at home

11. Industry or business at home

MOTHER FATHER { 12. Name Jacob Tencke
13. Birthplace Germany
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name _____
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature My John Cimber
(b) Address Sumner Ave

17. (a) burial (b) Date thereof 10-24-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director Walter Thompson
(b) Address Madison Mo

19. (a) Oct 24 47 (b) Leah Williams Love
(Date received local registrar) (Registrar's signature) 264

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? 6

While at work? _____ (Specify type of place) (e) Means of injury _____
28. Signature A. P. McCormick (M. D. or other) M.D.
Address Moberly Mo Date signed 10-22-47

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

OCT 27 1947

RECEIVED
District No. 10:49:146
Date Filed OCT 27 1947

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 Mrs. Leda A. Thompson
Licensed Embalmer No. 3282
P. O. Address Madison 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, above space should be left blank.