

No. 2
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 FILED MAY 18 1948

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 615938

Registration District No. 116 Primary Registration District No. 3070 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Washington mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Francis Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Franklin
 (c) City or town Union
(If outside city or town limits, write "RURAL")
 (d) Street No. South Oak St.
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Amelia Tessmer
 3. (b) If veteran, name war
 3. (c) Social Security No. X

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 5th
 year 1948 hour 12 minute 30 a.m.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased: September 12 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-29, 1948, to 5-5, 1948,
 that I last saw h. ex alive on 5-5, 1948,
 and that death occurred on the date and hour stated above.

8. AGE: Years 92 Months 7 Days 23
 If less than one day _____ hr. _____ min.

Immediate cause of death: Arterio sclerotic Cardiovascular Disease Duration 10 yrs
 Due to _____
 Due to _____

9. Birthplace Germany
(City, town, or county) (State or foreign country)
 10. Usual occupation House wife

Other conditions Dislocated rt Shoulder 8 days
(Includes pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name Cathiel Schilling
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Don't know
 15. Birthplace Don't know
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16. (a) Informant Mr. Lukas Tessmer
 (b) Address Union mo
 17. (a) Burial (b) Date thereof 5/9/48
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Union Cem Union
 18. (a) Signature of funeral director E. F. Ottmann
 (b) Address Washington mo
 19. (a) May 6 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 _____
 23. Signature B. J. Strickman (M. D. or other) M.D.
 Address Union, Mo Date signed 5-6-48

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

Streblman

.....
Date Filed MAY 17 1948

.....
District File Number

District Health Officer No. 9,

RECEIVED

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.....

E. F. Olmann

Licensed Embalmer No. 1686

P. O. Address Union 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 116Primary Registration District No. 3020Registrar's No. 63

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(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 days3. (a) PRINT FULL NAME Amelia Jessmer

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 _____

7. Birth date of deceased Sept 12 (Month) (Day) (Year)8. AGE: Years 92 Months 7 Days 3 If less than one day _____ yr. _____ min.9. Birthplace Germany (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 _____ (Burial, cremation, or removal) (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 May Year 1948 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 _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident(b) Date of occurrence 4-28-48(c) Where did injury occur? In home (City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place? In homeWhile at work? No (Specify type of place) (e) Means of injury Fell on stairs23. Signature B. H. Stuhlman (M. D. or other) M.D.Address Union, Mo Date signed 6-3-48

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

MOTHER FATHER

SUPPLEMENTARY

5-15738