S. No. 300
v. 10.48

FILED JAN 9 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42467

BIRTH NO. _____ REG. DIST. NO. 273 PRIMARY REG. DIST. NO. 5920 Registrar's No. 90

3740

1. PLACE OF DEATH
a. COUNTY: Perry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Union
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Perry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Union 3770
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): K.
c. (Last): Weinrich

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25 1951

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan 19 1885
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Perry Co. Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Ferdanand Bohnert
13b. MOTHER'S MAIDEN NAME: Barbara Horn
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Arnold Weinrich
ADDRESS: Perryville Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy, Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 3½ wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.

DUE TO (b) Hypertension — 10 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 334X
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 12-17, 1951 to 12-25, 1951, that I last saw the deceased alive on 12-25, 1951, and ~~that death~~ occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE: F. W. Eltz M.D. (Degree or Title)
23b. ADDRESS: Perryville, Mo.
23c. DATE SIGNED: 12-27-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 28 1951
24c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
24d. LOCATION (City, town, or county) (State): Longtown, Mo.

DATE REC'D BY LOCAL REG.: Dec 27-51
REGISTRAR'S SIGNATURE: Joe J. Zoellner
25. FUNERAL DIRECTOR'S SIGNATURE: Young & Sons
ADDRESS: Perryville Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed: Wallace Young

Licensed Embalmer No. 4027

P. O. Address Perryville 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.