MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED MAR 11 1940

7909
Do not use this space.

1. PLACE OF DEATH
(a) County Ray
(b) Township or (c) City Richmond
(d) Street No. ... St.
(e) Length of residence in city or town where death occurred 44 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

Registration District No. 744
Primary Registration District No. 3035
Registered No. 29
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Lena A. Kalbeloh
(a) Residence, No. N. Main St. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas. Kalbeloh
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 26-1864
7. AGE Years 75 Months 5 Days 1 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. —
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
10. Date deceased last worked at this occupation (month and year) —
11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
FATHER
13. NAME Phillip Herrmann
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
MOTHER
15. MAIDEN NAME Mary Steinhauer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
17. INFORMANT (ADDRESS) Charles Kalbeloh Richmond Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE City Cem. DATE 1-29 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. W. Mauzy Richmond Mo.
20. FILED Mar. 6, 1940 Mabel Jackson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jany. 27 1940
22. I HEREBY CERTIFY, That I attended deceased from Jan 20 1940, to Jan 27 1940, I last saw her alive on Jan 27, 1940. Death is said to have occurred on the date stated above, at 2a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	

Other contributory causes of importance —

Name of operation — Date of —
What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. —
Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? —
If so, specify —
(Signed) E. E. Gay M. D.
(Address) Richmond Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

I X16605

93 J

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3/8/40

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 A. W. Mansur, Registered ~~Apprentice~~ No. ..... working under my personal supervision.

Signed A. W. Mansur

Licensed Embalmer No. 1317

P. O. Address Richmond Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
—2-21-40
T X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7909

Registration District No. 744 Primary Registration District No. 3035 Registrar's No.

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond
(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)

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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lena A Kalberlah
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 M

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 75 | Months 5 | Days 1 | If less than one day hr. min.

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

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) (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 by local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jany day 27
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19, to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myo Carditis	
Due to 121	
Due to	
Other conditions (Include pregnancy within 3 months of death) Nephritis Chronic	
Major findings: Of operations No	
Of autopsy No.	

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature E E Gay (M. D. or other)
Address Richmond Date signed