

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.

JAN 17 1940

Registration District No. 508

Primary Registration District No. 3026

1. PLACE OF DEATH:  
 (a) County Linn  
 (b) City or town Chillicothe  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution V  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 1/2 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Cathrine Uhrmacher  
 3. (c) Social Security No. 652  
 8. (b) If veteran, name war ✓

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Single  
 6. (c) Age of husband or wife if alive 5 years (Day) (Year)  
 7. Birth date of deceased May 5, 1859  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>7</u>	<u>13</u>	hr. min.

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

10. Usual occupation ✓

11. Industry or business 6

MOTHER FATHER  
 12. Name Nicholas Uhrmacher  
 13. Birthplace Germany  
 (City, town, & county) (State or foreign country)

14. Maiden name Catherine Carbach  
 15. Birthplace Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rosa Williams  
 (b) Address Chillicothe, Mo.

17. (a) Burial (b) Date thereof Dec-21-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation May Cem

18. (a) Signature of funeral director James D. Gordon  
 (b) Address Chillicothe Mo

19. (a) 12-20-39 (b) H. W. ...  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo-1 (b) County Birnington  
 (c) City or town Rural  
 (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.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec - day 18<sup>th</sup>  
 year 1939 hour 8 minute 20 P. M.  
 21. I hereby certify that I attended the deceased from Dec 18  
 1939 to Dec 18, 1939  
 that I last saw her alive on Dec 18, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 1/2 hrs

Due to 870'

Other conditions arterial sclerosis 20 yrs  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings:  
 Of operations ✓  
 Of autopsy ✓  
 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)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature J. G. ... (M. D. or other) ✓  
 Address Chillicothe Mo Date signed 12/21/39

RECEIVED

District Health Officer No. 11;  
District File Number 100-1925  
Date Filed JAN-13-1940

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

*James D Gordon*

Licensed Embalmer No. 1870

P. O. Address *Chillicothe*

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.