

Registration District No. 759

Primary Registration District No. 6000

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: **FILED FEB 13 1940**  
 (a) County: St Charles  
 (b) City or town: Rural Callaway  
 (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 \_\_\_\_\_  
 In this community: Life  
 years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: Mo (b) County: St Charles  
 (c) City or town: Rural  
 (If outside city or town limits write "RURAL")  
 (d) Street No.: 3 Miles N.W. of Howell, Mo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME: Katie Rebling  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH, Month Jan day 6  
 year 1940 hour 6 minute 17 M.

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: Widowed  
 6. (b) Name of husband or wife: Wm Rebling 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years  
 7. Birth date of deceased: Nov 5, 1857  
 (Month) 2 (Day) 2 (Year) 82

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1939 to \_\_\_\_\_, 1940  
 that I last saw her alive on \_\_\_\_\_, 1939  
 and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 2 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Myocardial degeneration  
 Duration \_\_\_\_\_

9. Birthplace: St Charles Co  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation: House Wife

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions: Sensibility  
 (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
 12. Name: Dont know  
 13. Birthplace: Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name: Dont know  
 15. Birthplace: Dont know  
 (City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant: Edward Rebling  
 (b) Address: Hamburg, Mo

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof: Jan 8, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation: New Mville Mo  
 18. (a) Signature of funeral director: Morris Muschany  
 (b) Address: Hamburg, Mo  
 19. (a) 1-9-40 (b) OO. Mulschany  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature: N.C. Mulschany (M. D. or other) 1740  
 Address: New Mville, Mo Date signed: 1/7/40

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

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**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 Morris Muschany

Licensed Embalmer No. 2461

P. O. Address Hamburg, 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.**