

FILED FEB 17 1940
Registration District No. **51**

Primary Registration District No. **4588**

Registrar's No. **1**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1. PLACE OF DEATH:

(a) County Scott **2**

(b) City or town Farmfleet

(c) Name of hospital or institution: Farmfleet Missouri
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution Residence
(Specify whether years, months or days) 35 years

In this community 35 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Farmfleet
(If outside city or town limits, write "RURAL")

(d) Street No. Farmfleet Missouri
(If rural, give location)

(e) If foreign born, how long in U. S. A. ✓ years.

3. (a) PRINT FULL NAME Mary Georger

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female **5. Color or race** white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife John Georger

6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased October 22 1858
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>3</u>	<u>5</u>	hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business none

MOTHER FATHER

12. Name Charles Scheeter

13. Birthplace Alsace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Witt

15. Birthplace Alsace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Bert Miller

(b) Address 9248 E. Pennsylvania St.

17. (a) Burial, cremation, or removal Burial

(b) Date thereof Jan 29 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Res. Missouri

18. (a) Signature of funeral director Arthur C. Crowell

(b) Address Farmfleet, Mo.

19. (a) 1-29-1940 **(b) Paul Gray**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27
year 1940 hour 7 minute 55 A.M.

21. I hereby certify that I attended the deceased from Jan 4, 1940, to Jan 27, 1940
that I last saw her alive on Jan 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Suppurative

Other conditions 93C
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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?

While at work? (Specify type of place)

(e) Means of injury

23. Signature J. J. Dorian (M. D. or other)

Address Illness. Mo. **Date signed** 1-29-40

RECEIVED

District Health Officer No. 2

District File Number 240 - 590

Date Filed 2/9/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.