

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10909

Registration District No. 305

Primary Registration District No. 4184

Registrar's No. 7

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

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

3. (a) PRINT FULL NAME FLOYD JUNIOR MISTLER
 3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife NONE
 6. (c) Age of husband or wife if alive NONE years
 7. Birth date of deceased DEC. 20 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 2 25 hr. min.

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

10. Usual occupation NONE

11. Industry or business NONE

MOTHER FATHER { 12. Name FLOYD MISTLER
 13. Birthplace CUBA MISSOURI
(City, town, or county) (State or foreign country)
 14. Maiden name VERNA GLASER
 15. Birthplace WASHINGTON MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Floyd Mistler
 (b) Address OWENSVILLE MO.

17. (a) BURIAL (b) Date thereof MAR. 16 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation OWENSVILLE CITY CEM.

18. (a) Signature of funeral director W.F. Gottenrater
 (b) Address OWENSVILLE MO.

19. (a) (b) !
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County GASCONADE
 (c) City or town OWENSVILLE
(If outside city or town limits write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 15
 year 1940 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 4
43-12- 1940 to 3-15- 1940
 that I last saw him alive on 3-14 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral

Due to Pneumonia Bronchial

Due to _____

Other conditions 1912
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? 928

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

23. Signature Edwin Mellies (M. D. or other) !
 Address Owensville Mo Date signed 3-15-40

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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.....

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

Signed Milford H. H. Winter

Licensed Embalmer No. 3838

P. O. Address Owensville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10909

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 305

Primary Registration District No. 4184

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Gasconade

(b) City or town Quenerville
(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)

3. (a) PRINT FULL NAME Floyd Junior Mutter

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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 Months Days If less than one day

2 25 _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/18/40 (b) Leith A. Bannister
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH: Month Mar day 15 year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration _____

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 Edw Mellies (M. D. or other) _____

Address Quenerville Date signed _____

SUPPLEMENTARY

1940
S-10909