

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10912

Registration District No. 305

Primary Registration District No. 5423

Registrar's No. 6

1. PLACE OF DEATH:

(a) County GASCONADE
 (b) City or town RURAL BRUSH CREEK TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
OWENSVILLE ROUTE 3
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 4 1/2 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE
 (c) City or town RURAL
(If outside city or town limits, write "RURAL")
 (d) Street No. OWENSVILLE MO. ROUTE 3
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 11
 year 1940 hour UNKNOWN minute _____ M.

21. I hereby certify that I attended the deceased from
September 14, 1939, to 3-11, 1940.
 that I last saw him alive on 3-4, 1940.
 and that death occurred on the date and hour stated above.

Immediate cause of death Branch of Spleen & Stomach
 Duration _____

Due to _____
 Due to _____

Other conditions _____
(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 Edw Mellies (M. D. or other) _____
 Address Owensville Mo Date signed 8-12-40

3. (a) PRINT FULL NAME BERTHA AMELIA ZOCH 200

8. (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 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 JAN 26 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE WORK

11. Industry or business _____

MOTHER FATHER { 12. Name ALBERT ZOCH

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

14. Maiden name JOHANNA ROSINA

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

16. (a) Informant's own signature Wm. J. Kinnear

(b) Address Owensville Mo R# 3

17. (a) BURIAL (b) Date thereof 3-14-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BEM. EV. CEM.

18. (a) Signature of funeral director W.F. Gottenstein

(b) Address OWENSVILLE Mo
 19. (a) 3-16-40 (b) Arthur A. Brown
(Date received local registrar) (Registrar's signature)

4/15

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.....

Lloyd Ficke....., Registered Apprentice No. 247

working under my personal supervision.

Signed W. F. Gettenstrater.....

Licensed Embalmer No. 1444

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. 10912

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 305

Primary Registration District No. 5423

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Burns Creek T. 9.
(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

Bertha Amelia Zoch

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced S
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 68 Months 1 Days 15 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 { 12. Name _____
FATHER { 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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 11 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 Cancer of Stomach Duration _____
liver and stomach
pituitary and of stomach

Due to _____
Due to Cancer Ulcers of stomach

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

Major findings: Of operations 46
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) (c) Means of injury _____

23. Signature Edw Mellican (M. D. or other) _____
Address Quincyville _____

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

SUPPLEMENTAL

1940

S-10912