

AUG 10 1940 305

Primary Registration District No. 5422

Registrar's No. 20

1. PLACE OF DEATH:  
(a) County Gasconade  
(b) City or town Rural CANTAN  
(c) Name of hospital or institution:  
Owensville Route 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 65 YRS  
years, months or days.

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Gasconade  
(c) City or town Rural  
(d) Street No. Route #1  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Josie Aytes 320  
3. (b) If veteran name war \_\_\_\_\_ No. \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 3  
year 1940 hour 8 minute 15 A. M.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Alonso Aytes 6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased August 7 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1, 1940 to 7-3, 1940  
that I last saw him alive on 7-1, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 10 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Uremia  
Duration 3 Days

9. Birthplace Owensville R. #1 Missouri  
(City, town, or county) (State or foreign country)

Due to Chc. Nephritis  
Due to Hypertension

10. Usual occupation House work

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business own home  
12. Name W.P. Woodroff  
13. Birthplace Gasconade Missouri  
14. Maiden name Martha Melton  
15. Birthplace Gasconade Missouri

Major findings: Of operations ✓ 121  
Of autopsy ✓  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Charles Drew  
(b) Address Billie Mo

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof July 6 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation new Salem Cem Owensville Mo

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

18. (a) Signature of funeral director W.F. Sattin  
(b) Address Owensville Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 928  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

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

23. Signature Charles Schmidt (M. D. or \_\_\_\_\_)  
Address Gerald Date signed 7-3-40

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

**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 Stike*....., Registered Apprentice No. *247*  
working under my personal supervision.

Signed *W.F. Gattenstroter*  
Licensed Embalmer No. *1484*  
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. 85735

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 305

Primary Registration District No. 3422

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

1. PLACE OF DEATH:

(a) County Gascoyne  
(b) City or town Canaan T.P.  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

Jasie Aytes

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 65 Months 10 Days 26 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) 8-8-40 (b) Steth A. Burmeister, M.D. (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw h. \_\_\_\_\_ 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 Chas Schmidt (other) \_\_\_\_\_

Address Gerald Date signed \_\_\_\_\_

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

SUPPLEMENTARY

