DEPARTMENT OF CO[redacted]CE
BUREAU OF THE CE[redacted]

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

NOV 1[redacted] NOV 1[redacted] 35170

State File No.

Registration District No. 298 Primary Registration District No. 5344 Registrar's No.

1. PLACE OF DEATH:

(a) County DAVIESS Liberty 4

(b) City or town R.R.I ALTAMONT
(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 2 (Specify whether years, months or days)

In this community LIFE TIME

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 HATTIE E. REID

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased JAN (Month) 10 (Day) 1857 (Year)

8. AGE: Years 83 Months 4 Days 0 If less than one day hr. min.

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

10. Usual occupation House Wife 9

11. Industry or business

FATHER
12. Name NICHOLES FATZINGER 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Allie A. Wilson
(b) Address Altamont

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-40 (Month) (Day) (Year)
(c) Place: burial or cremation Altamont

18. (a) Signature of funeral director Mrs Kate Stamp
(b) Address Winston

19. (a) 9-20-40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 year 1940 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from Feb 1, 1940, to May 9, 1940 that I last saw her alive on May 9, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemog. | Duration

Due to Artera Sclerosis

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

23. Signature J. Z. Parker (M. D. or other) MD
Address Plattsburg Date signed 9-2-40

(Licensed Embalmer's Statement on Reverse Side)

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.

I X19511

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 me

....., Registered Apprentice No.....,

working under my personal supervision..

Signed Virgil V. Stroup

Licensed Embalmer No. 4074

P. O. Address Winston

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.