

FEB 14 1941

Registration District No. 4184

Primary Registration District No. 305

Registrar's No. 2

1. PLACE OF DEATH:

(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: ✓ 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution ✓ (Specify whether)  
 In this community 48 YEARS. (years, months or days)

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.

3. (a) PRINT FULL NAME MARIE SOPHIA WARDEN

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CHARLES N. WARDEN 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased JULY 8 1866  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>6</u>	<u>22</u>	<u>✓</u> hr. <u>✓</u> min.

9. Birthplace LANES PRAIRIE MISSOURI  
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business ✓

12. Name FREDERICK W. WENTZEL

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

14. Maiden name MARIE LOUISA SOPHIA SCHRAMK

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

16. (a) Informant Mrs. Claire Hutton  
 (b) Address White City, Kansas

17. (a) BURIAL (b) Date thereof FEBRUARY 2 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OWENSVILLE CITY CEMETERY

18. (a) Signature of funeral director H. J. Gottenstreter

(b) Address Owensville, Mo.

19. (a) Jan 31-41 (b) Robert M. Murray  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 30  
 year 1941 hour 10:00 minute — P.M.

21. I hereby certify that I attended the deceased from 1-29 to 1-30, 1941  
 that I last saw him alive on 1-30, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia due to Hipfracture  
 Due to Septicemia due to Hipfracture

Due to \_\_\_\_\_  
 Other conditions (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? \_\_\_\_\_

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

23. Signature Edno Wellies (M. D. or other) D  
 Address Owensville Mo Date signed 1-31-41

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

MOTHER FATHER

37  
2  
0

832

**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 Melford Hinton

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

Registration District No. 305-

Primary Registration District No. 4184

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

1. PLACE OF DEATH:

(a) County Wassonade  
(b) City or town Owensville Mo  
(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 Marie Sophie Varden

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 W

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 74 Months 6 Days 22 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ 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) \_\_\_\_\_ (b) \_\_\_\_\_ (Data 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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month Jan day 30

year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death: Pneumonia  
Sepsis  
light stroke due to  
Hypertension  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

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

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN  
Underline (the cause to which death should be charged statistically).

