No.
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2905

FILED JAN 21 1943

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 55

1. PLACE OF DEATH:

(a) County: MORGAN.
(b) City or town: VERSAILLES. (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 ..... In this community LIFETIME. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI. (b) County: MORGAN. 71 1
(c) City or town: VERSAILLES. (If outside city or town limits, write "RURAL") 0
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: KAROLINA K. DUFF.

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: 2 WIDOWED.
6. (b) Name of husband or wife: .....
6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: MCH. (Month) 25, (Day) 1860 (Year)

8. AGE: Years 82, Months 9, Days 5. If less than one day ..... hr. ..... min.

9. Birthplace: MORGAN CO., (City, town, or county) MO. (State or foreign country)
10. Usual occupation: AT HOME.
11. Industry or business: HOME.

FATHER
12. Name: MATHIAS GATTERMEIR.
13. Birthplace: VIENNA, (City, town, or county) AUSTRIA (State or foreign country)

MOTHER
14. Maiden name: ANNA WINGLER.
15. Birthplace: VIENNA, (City, town, or county) AUSTRIA (State or foreign country)

16. (a) Informant: Mrs. M. D. Marrott.
(b) Address: Versailles, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/1/43. (Month) (Day) (Year)
(c) Place: burial or cremation: Versailles Cem'ty.

18. (a) Signature of funeral director: W. F. Thurnell
(b) Address: Versailles Mo.

19. (a) 1-1-1943 (Date received local registrar) (b) Roy Berkstresser (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 30TH. year 1942. hour 12. minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec 19, 1942 to Dec 30, 1942 that I last saw him alive on Dec 30, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	11 days
Due to:	
Due to: arterio sclerosis	unknown
Other conditions: Hypertension (Include pregnancy within 3 months of death)	unknown

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: A. J. Gunn (M. D. or other)
Address: Versailles Mo. Date signed 12/31/42

1027

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 12-42-1408
Date Filed 1-12-43

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.....

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

working under my personal supervision.

Signed E. F. Kidwell

Licensed Embalmer No. 1596

P. O. Address Lisbon Me.

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, fact should be so stated above.

S. No. 2B
1—8-21-41
P I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 2905

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 55

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

1. PLACE OF DEATH:

(a) County: Morgan

(b) City or town: Versailles
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Karolina K. Duff

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 years

7. Birth date of deceased: March (Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days If less than one day hr. min.

9. Birthplace: Morgan Co (City, town, or county) MO (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 30 year 1942 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: Uremia

Due to: Chronic Nephritis unknown

Due to: arterio sclerosis

Other conditions: Hypertension
(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)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY