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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32168**  
Registrar's No. **17**

Registration District No. **234**

Primary Registration District No. **5816**

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

1. PLACE OF DEATH:  
(a) County **Morgan**  
(b) City or town **Ottewille Mo**  
(c) Name of hospital or institution **Richland Hosp**  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME **Galdie Evelyn Patter**  
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 **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
7. Birth date of deceased **7 27 1911**  
(Month) (Day) (Year)

8. AGE: Years **32** Months **1** Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Morgan Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

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

12. Name **Not Known**

13. Birthplace **Ottewille Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Vienna Bell Weaver**

15. Birthplace **Morgan Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Patter**

(b) Address **Ottewille**

17. (a) **Ottewille** (b) Date thereof **9-4-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ottewille**

18. (a) Signature of funeral director **Parthen Funeral Service**  
(b) Address **Ottewille**

19. (a) **Sept 30 43** (b) **Henry Kipp**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County **71**  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") **0**  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **9** day **4**  
year **1943** hour **8** minute **0** M.

21. I hereby certify that I attended the deceased from **10 43** to **9-4-43** 19**43**  
that I last saw h. **4** alive on **9-4-43** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia (Right)**  
**Pulmonary Tuberculosis**  
Due to \_\_\_\_\_  
Duration \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
13 fl

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? \_\_\_\_\_

23. Signature **E. E. H. H. H.** (M. D. or other) **9/5/43**  
Date signed \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

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

1032

RECEIVED

District Health Officer No. 7,

District File Number

Date Filed

9-43-48

10-13-43

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.....

my self

Registered Apprentice No.....

working under my personal supervision.

Signed.....

L. Y. Parker

Licensed Embalmer No.....

25-47

P. O. Address.....

Bruneton 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, fact should be so stated above.

02475

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32168  
State File No. *ack*  
Registrar's No. 17

Registration District No. 234 Primary Registration District No. 5816

1. PLACE OF DEATH:

(a) County Morgan  
(b) City or town Richland Twp  
(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 Mo (b) County Morgan  
(c) City or town Richland Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. Otterville Mo  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Goldie Evelyn Patten

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

4. Sex ♀ 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 July 27  
(Month) (Day) (Year)

8. AGE: Years 32 Months 1 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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 September day \_\_\_\_\_  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her 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 \_\_\_\_\_

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 \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

