No. 2
—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17899

FILED JUN 13 1945

Registration District No. 2

Primary Registration District No. 3056

Registrar's No. 97

1. PLACE OF DEATH:

(a) County: Randolph

(b) City or town: Moberly (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: McCormick Hospital (If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 14 Days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Chariton

(c) City or town: Brunswick (If outside city or town limits, write "RURAL") 21

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME: Millie Sasse

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: Single

6. (b) Name of husband or wife

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

7. Birth date of deceased: February (Month) 23 (Day) 1863 (Year)

8. AGE: Years 82 Months 2 Days 28 If less than one day hr. min.

9. Birthplace: Brunswick (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Homemaker

11. Industry or business

FATHER 12. Name: Henry Sasse

13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Philipina Meyer

15. Birthplace: Germany (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Pena Heisel

(b) Address: Brunswick Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Lower Cemetery

18. (a) Signature of funeral director: John H. Meyer

(b) Address: Brunswick Mo.

19. (a) 5-26-45 (Date received local registrar) (b) Dina Kaul (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 21 year 1945 hour 7 minute 430 P.M.

21. I hereby certify that I attended the deceased from 5-2, 1945 to 5-21, 1945 that I last saw her alive on 5-21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia — Duration 3 da.

Due to: Fracture hip Left — 15 da.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following: 021

(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: G. L. McCormick (M. D. ~~or other~~) MD

Address: Moberly Mo Date signed 5-21-45

1036

(Licensed Embalmer's Statement on Reverse Side)

JUN 20 1945

RECEIVED
District Health Officer No. 10
District File Number 6-45-284
Date Filed JUN 12 1945

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 D. L. Leupard

Licensed Embalmer No. 3970

P. O. Address Mendon 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.

No. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 97

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: U
(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 Millie Sasse
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 23 1866 (Month) (Day) (Year)
8. AGE: Years 82 Months Days If less than one day hr. min.
9. Birthplace (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 Mar Day 21 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident
(b) Date of occurrence Apl. 2 - 45
(c) Where did injury occur? Brunswick Chariton Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home (Specify type of place)
While at work? yes (e) Means of injury Fell
23. Signature F. L. McCormick (M.D. or other) M.D.
Address Moberly Mo Date signed 6-13-40

SUPPLEMENTARY

17899