No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

20920

State File No.

FILED JUL 9 1945

Registration District No. 245 Primary Registration District No. 5837 Registrar's No. 63

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1. PLACE OF DEATH:
(a) County Newton
(b) City or town Camp Crowder, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ASF Regional Sta Hosp, Camp Crowder, Mo. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days) In this community 3 April 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Germany (b) County
(c) City or town Soraulausitz (If outside city or town limits, write "RURAL")
(d) Street No. Oberstrasse 10 (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3. (a) PRINT FULL NAME Karl (none) Buth
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charlotte Buth
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 8 (Day) 1910 (Year)

8. AGE: Years 35 Months 1 Days 25 If less than one day hr. min.

9. Birthplace Germany (City, town, or county) U (State or foreign country)
10. Usual occupation Soldier
11. Industry or business German Army
FATHER 12. Name Unknown
13. Birthplace (City, town, or county) 4 (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) 4 (State or foreign country)
16. (a) Informant Soldier's Service Record
(b) Address Camp Crowder, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 4 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Camp Clark, Mo.
18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri
19. (a) 6-4-1945 (Date received local registrar) (b) Corly Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2 year 1945 hour 12 minute 50 P.M.
21. I hereby certify that I attended the deceased from 3 April, 1945, to 2 June, 1945; that I last saw him alive on 2 June, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis, subacute, Bacterial — Duration
Valvular heart disease; mitral in sufficiency, aortic insufficiency.
Due to Decompensation with ascites
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 Donald W. Trotter (M. D. or other) MMC
Address Camp Crowder, Mo. Date signed 6/4/45

1110

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED JUL 3 1945

District Health Officer No.....

District File Number 645-96

Date Filed JUL 3 1945

Signed Emma L. Kneel

Licensed Embalmer No. 391

P. O. Address Carthage

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.