

S. No. 2
M-3-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33178**

FILED OCT 24 1945

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **1062**

1. PLACE OF DEATH:
(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1401 JULES**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 months** (Specify whether years, months or days)
In this community **5 months**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **DeKalb 321**
(c) City or town **Monroeville** (If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **FRONIA ALICE GOTTSCHE**
3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **3** year **1945** hour **5** minute **P.M.**
21. I hereby certify that I attended the deceased from **Aug 27, 1945**
that I last saw him **alive on** **Sept. 18** **1945**
and that death occurred on the date and hour stated above.

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Widowed**
6. (b) Name of husband or wife **Henry Gottschal** **6. (c) Age of husband or wife if alive** **✓** years
7. Birth date of deceased **Oct 18, 1867**
(Month) (Day) (Year)

Immediate cause of death
Coronary occlusion 1 hr.
Due to **chronic myocarditis 5 yr.**
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
93d
Of autopsy

8. AGE: Years **77** Months **11** Days **15** If less than one day hr. min.

9. Birthplace **Bayport Texas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Ashby Peters**

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

14. Maiden name **Caroline Shaw**

15. Birthplace **?** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henry Gottschal**

(b) Address **St. Joseph Mo**

17. (a) Burial **Oct 5 1945** **(b) Date thereof** **Oct 5 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Using Chapel**

18. (c) Signature of funeral director **Wm. W. Johnson**

(b) Address **MO**

19. (a) 10/5/1945 **(b) W. W. Johnson**
(Date received local registrar) (Registrar's signature)

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) Means of injury
23. Signature **Wm. W. Johnson** (M. D. or other)
Address **620 Francis** **Date signed** **10/5/45**

Duration
1 hr.
5 yr.
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

1428 (Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

D. V. Foothaker

731 Farrow H, 1459

1507 711 2,5110

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 G. M. Atchison

Licensed Embalmer No. 2279

P. O. Address Jacksonville, 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: