V. S. No. 2
0M—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36791

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 360

14
1
2

1. PLACE OF DEATH:

(a) County Calloway

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

(c) Name of hospital or institution: Stat Hosp No 1 2 (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 1 yr 8 month 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage 14

(c) City or town Meta (If outside city or town limits, write "RURAL") 2

(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 ELIZABETH WANSING

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 2 widow

6. (b) Name of husband or wife .....

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

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

8. AGE: Years 71 | Months | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation housewife

11. Industry or business .....

FATHER
12. Name DK
13. Birthplace ..... (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace ..... (City, town, or county) 9 (State or foreign country)

16. (a) Informant Records Stat Hosp No 1

(b) Address Fulton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27-45 (Month) (Day) (Year)

(c) Place: burial or cremation Meta Mo

18. (a) Signature of funeral director H H Strop

(b) Address Meta Mo

19. (a) 11-24-1945 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

1141

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 24 day 24 year 1945 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from Nov 2 1945, to Nov 24, 1945 that I last saw her alive on Nov 24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Interstitial Nephritis	
Due to	
Due to	
Other conditions Bronchial Pneumonia (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 1 3/0	

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 R Price (M. D. or other) MD

Address Fulton Mo Date signed 11-24-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED,
District Health Officer No. 9,
District Filo. Number
Date Filed 12-1-45

DEC 13 1945

APR 9 1947

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 H H Strop

, Registered Apprentice No.
working under my personal supervision.

Signed H H Strop

Licensed Embalmer No. 2924

P. O. Address Meta 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.