

FILED JAN 11 1945
Registration District No. **82**

Primary Registration District No. **3017**

Registrar's No. **149**

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

1. PLACE OF DEATH:

(a) County **COOPER**

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

(c) Name of hospital or institution: **ST. JOSEPH'S HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **45 DAYS**
(Specify whether years, months or days)

In this community **45 DAYS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER**

(c) City or town **SPEED**
(If outside city or town limits, write "RURAL")

(d) Street No. **NONE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **MRS SOPHIA OTT**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **20th**
year **1945** hour **9** minute **8** A. M.

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

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

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

7. Birth date of deceased **FEBRUARY 22 1864**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 1**, 19**45**, to **Dec 20**, 19**45**
that I last saw him alive on **Dec 20**, 19**45**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
81	9	28 hr. min.

Immediate cause of death **Cerebral arteriosclerosis**

Duration

9. Birthplace **COOPER COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

Due to.....

Due to.....

10. Usual occupation **HOUSEWIFE**

Other conditions **myocarditis**
(Include pregnancy within months of death)

11. Industry or business **HOME**

Major findings: Of operations **none**

12. Name **WILLIAM REED**

Of autopsy **none**

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

14. Maiden name **MARY REED**

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

16. (a) Informant **JOHN REED**

(b) Address **OTTERVILLE, MO.**

17. (a) **BURIAL** (b) Date thereof **12/22/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **JEFFERSON CITY, MO.**

18. (a) Signature of funeral director **STEGNER-KOENIG BOONVILLE, MO.**

(b) Address.....

19. (a) **Dec 22** (b) **Clay Marris**
(Date received local registrar) (Registrar's signature)

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?.....

While at work?.....
(Specify type of place) (e) Means of injury.....

23. Signature **T. C. Beckett, MD** (M. D. or other) **MD**
Address **Boonville, Mo** Date signed **12-21-45**

1639

1-9-46

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 James W Stegner
Licensed Embalmer No. 3780
P. O. Address Boonville, 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.