V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2300

FILED FEB 7 1946

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 1

14
1
2

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hosp No 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Yrs 7 Mo 7 Day (Specify whether)

In this community sam
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade 14

(c) City or town Bland 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CHRISTINE RIESBEL

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 DK (Month) (Day) (Year)

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Lonsmark

11. Industry or business

FATHER
12. Name DK
13. Birthplace (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name DK
15. Birthplace (City, town, or county) (State or foreign country) 0

16. (a) Informant Records State Hosp No 1
(b) Address Fulton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Grounds

18. (a) Signature of funeral director C C Thomas
(b) Address 302 Market St Fulton Mo

19. (a) Jan 7-1945 (Date received local registrar) (b) Josie Morsinek Scott (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 1 year 1946 hour 8 minute 269 M.

21. I hereby certify that I attended the deceased from ~~Jan~~ Dec 1-1945, 19 to Jan 1, 1946 that I last saw her alive on Dec 31, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pernicious Anemia	
Due to	
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.

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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 [signature] (M.D. or other)

Address Fulton Mo Date signed 1-1-46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 25-46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.