

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 7 1946
STANDARD CERTIFICATE OF DEATH

State File No. **30912**
Registrar's No. **106**

Registration District No. **187** Primary Registration District No. **3046**

1. PLACE OF DEATH:
(a) County Lickingstone
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
203-Webster
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lickingstone
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 203-Webster
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William A. Nottwagle
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 6
year 1946 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from None
21 None, 19 , to None, 19 ;
that I last saw him alive on None, 19 ;
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Amanda A. 6. (c) Age of husband or wife if
12 alive years
7. Birth date of deceased Sept. 7-1864
(Month) (Day) (Year)

Immediate cause of death Gun shot wound in chest
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

8. AGE: Years 81 Months 11 Days 29
If less than one day hr. min.

9. Birthplace Liv. Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer - Retired

MOTHER FATHER
11. Industry or business _____
12. Name Michael Nottwagle
13. Birthplace Germany
14. Maiden name Elizabeth Miller
15. Birthplace Germany

PHYSICIAN
Major findings: Disease of heart and diabetes
Of operations _____
Of autopsy _____

16. (a) Informant Mrs. Grace Barnes
(b) Address St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-1946
(Month) (Day) (Year)
(c) Place: burial or cremation Edge Wood Cem.
18. (a) Signature of funeral director Ronald F. Gordon
(b) Address Chillicothe Mo.
19. (a) Sept-9-1946 (Date received local registrar) (b) Frances B. Neel (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) suicide
(b) Date of occurrence Sept-6-1946 Lickingstone
(c) Where did injury occur? Sept-6-Chillicothe, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In yard at home
While at work? _____ (Specify type of place)
(e) Means of injury 5
23. Signature R. Barnes Deputy Coroner
Address Chillicothe Mo Date signed 9-9-46

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

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *Ronald F. Gordon*

Licensed Embalmer No. *4191*

P. O. Address..... *Phillipsville, 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.