

S. No. 2
1-9-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40165

Registration District No. 115

Primary Registration District No. 5433

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Gertrude Mueller

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W.

6. (a) Single, widowed, married, divorced W. 2

6. (b) Name of husband or wife _____

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

7. Birth date of deceased April 6 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>8</u>	<u>11</u>	_____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or Business _____

MOTHER FATHER

12. Name John Wisseman

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

14. Maiden name Wisseman

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

16. (a) Informant John B. Mueller

(b) Address Beaufort Mo

17. (a) Rural (b) Date thereof Dec 19 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation near mo

18. (a) Signature of funeral director J. J. Semme

(b) Address Beaufort Mo

19. (a) Dec 18 1946 (b) J. J. Cooper et al
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

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

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1946 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 2 1946 to Dec 17 1946
that I last saw her alive on Dec 11 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis Duration 2 years

Due to _____

Due to _____

Other conditions: AD
(Include pregnancy within 3 months of death)

Major findings: No operation

Of operations _____

Of autopsy No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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? Yes (Specify type of place) _____

23. Signature J. H. Matthews (M. D. or other) _____

Address Beaufort Mo Date signed 12-18-46

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

RECEIVED
District Health Officer No. 9,
District File Number
Date filed 12-23-46

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.....

working under my personal supervision.

E. H. Terrence

Registered Apprentice No.....

Signed.....

E. H. Terrence

Licensed Embalmer No. 3076

P. O. Address Beaufort 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.