

Registration District No. **115**

Primary Registration District No. **4187**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution:
24 E. Park St. 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 24 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

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

(d) Street No. 24 E. Park Ave.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Anna Platt

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month August, day 15th
year 1947 hour 11 minute 45 P.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 May 7th 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-13 1947 to 8-15 1947
that I last saw him 01 alive on 8-4 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>3</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Arteriosclerotic Cardiovascular Disease

Due to _____

Due to _____

Duration 6 yrs

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

10. Usual occupation House work

Other conditions Diabetes Mellitus 10 yrs
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name Peter Schelish

13. Birthplace Don't Know
(City, town, or county) (State or foreign country)

14. Maiden name Sophia Kamphelm

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy 61

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Henry Platt

(b) Address Union mo

17. (a) Burial (b) Date thereof 8/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union mo

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? _____

18. (a) Signature of funeral director E. F. Ottman

(b) Address Union mo

19. (a) Aug 17 1947 (b) F. T. Cooper
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury 0

23. Signature B. J. Trubman (M. D. or other) M.D.

Address Union, Mo Date signed 8-16-47

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

6190

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed AUG 28 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *E. F. Oltram*.....
Licensed Embalmer No. *1686*.....
P. O. Address *Union 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.