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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32204**

FILED OCT 29 1948

Registration District No. **77**

Primary Registration District No. **3008**

Registrar's No. **304**

1. PLACE OF DEATH: **Callaway**

(a) County **Callaway**

(b) City or town **Fulton 202 Nichols St.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **/**
(If not in hospital or institution, write street number or location)

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

In this community **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Kate Willhagen**

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 **Widowed**

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

6. (c) Age of husband or wife if alive **27** years (Day) (Year)

7. Birth date of deceased **Nov. 27 1857**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	10	21	hr. _____ min.

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

10. Usual occupation **Home**

11. Industry or business: _____

MOTHER FATHER { 12. Name **August Fischer**

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

14. Maiden name **Margretta Wischman**

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

16. (a) Informant **Mary Schmidt**

(b) Address **202 Nichols St. Fulton, Mo**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **10-20-48**
(Month) (Day) (Year)

(c) Place: burial or cremation **Hillcrest**

18. (a) Signature of funeral director **Hallace Funeral Home**

(b) Address **8 W 6th St. Fulton, Missouri**

19. (a) **10-22-1948** (Date received local registrar)

Jose A. Moseley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri**

(b) County **Callaway**

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

(d) Street No. **202 Nichols**
(If rural, give location)

(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country **Germany**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **18**
year **1948** hour **6** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **October 5**
1948, to **October 16** **1948**;
that I last saw **her** alive on **October 16** **1948**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic interstitial nephritis**

Duration **10 yrs.**

Due to _____

Due to _____

Other conditions **Apoplexy**
(Include pregnancy within 3 months of death) **4 days**

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: _____

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 **2**
D. A. Squires (M.D. or other) **D.O.**

Signature **D. A. Squires**

Address **Fulton, Missouri**

Date signed **10-19-48**

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

Date of Issue
OCT 28 1948
District Director No. 9

NOV 9 1948

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 *Penzil C. Browning*
Licensed Embalmer No. *2724*
P. O. Address *Tullon md*

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.