

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33484**

FILED NOV 1 1948

Registration District No. **187**

Primary Registration District No. **3.040**

Registrar's No. **140**

1. PLACE OF DEATH:

(a) County **Livingston**  
(b) City or town **Chillicothe**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Chillicothe Hos pital 0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 days**  
(Specify whether years, months or days)  
In this community **24 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Livingston**  
(c) City or town **Chillicothe**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **West Third Street**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

3: (a) PRINT FULL NAME **Salome Louise "Lona" Wichmann**

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 **Married**  
6. (b) Name of husband or wife **Ben A. Wichmann**  
6. (c) Age of husband or wife if alive **65** years  
7. Birth date of deceased **October 26 1987**  
(Month) (Day) (Year)

8. AGE: Years **60** Months **10** Days **28**  
If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER {  
12. Name **John Roth**  
13. Birthplace **St. Genevive, Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Margaret Ohland**  
15. Birthplace **Hamburg, Germany**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ben A. Wichmann**  
(b) Address **R.R. #4 Chillicothe, Missouri**

17. (a) **Burial** (b) Date thereof **9-27-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Catholic Cemetery**

18. (a) Signature of funeral director **Norman Funeral Home**  
(b) Address **Chillicothe, Missouri**

19. (a) **Oct-20-48** (b) **Frances B Neill**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **24th**  
year **1948** hour **2** minute **05 P.** M.

21. I hereby certify that I attended the deceased from **Aug 10 1948 to Sept 24 1948**  
that I last saw him alive on **Sept 24 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Obstruction of urinary bladder**  
Duration **4 min**

Due to  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **52 B**  
Of operations  
Of autopsy

PHYSICIAN  
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?

(Specify type of place)  
While at work (a) Means of injury  
23. Signature **W. J. Russell** (b) **Chillicothe, Mo.** Date signed **9/24/48**  
Address Date signed

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

59  
1  
2

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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**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 Ellen Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

**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.**