

No. 2
1/47
17-39

National Office of Vital Statistics
FILED NOV 24 1948

Registration District No. **756-114**

Primary Registration District No. **44-4186**

Registrar's No. **90**

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

1. PLACE OF DEATH:

(a) County **FRANKLIN**

(b) City or town **SULLIVAN**
(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 **32 yrs.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **FRANKLIN**

(c) City or town **SULLIVAN**
(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 _____

3. (a) PRINT FULL NAME **BERTHA MAY BETZ**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **FEMALE** 5. Color of race **White**

6. (a) Single, widowed, divorced, **married**

6. (b) Name of husband or wife **Chas. Betz**

6. (c) Age of husband or wife if alive **71** years

7. Birth date of deceased **Dec 12 1875**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	11	5	hr. _____ min _____

9. Birthplace **Blue Mound Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **OWEN SIEBERLING**

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

14. Maiden name **JANE POWERS**

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

16. (a) Informant **CHAS. S. BETZ**

(b) Address **SULLIVAN MO**

17. (a) **BURIAL** (b) Date thereof **11/19/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **1005 SULLIVAN MO**

18. (a) Signature of funeral director **Thos. P. Shaffer**

(b) Address **Sullivan MO**

19. (a) **11-18-48** (b) _____
(Date received local registrar) (Date of death)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **17**
year **1948** hour **5** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **1936** to **11-17-48**
that I last saw her alive on **11-16-48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **arteriosclerosis**

Due to **hypertension**

Other conditions **no**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____ (e) Means of injury _____

23. Signature **Ch. Tractor** (M. D. or other) _____
Address **Sullivan Mo** Date signed **11/19/48**

Duration **15 days**

PHYSICIAN _____

Underline the cause of which death should be charged statistically.

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed NOV 23 1948

APR 3 1992

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 Edgar W. Laffoon
Licensed Embalmer No. 2394
P. O. Address Sullivan 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.