

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15478

State File No.

FILED JUN 9 1949

BIRTH NO. _____ REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 4193 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hermann</u>		c. LENGTH OF STAY (In this place) <u>52 yrs</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hermann</u>		d. STREET ADDRESS (If rural, give location) <u>113 Schiller St</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>113 Schiller St</u>		e. STREET ADDRESS (If rural, give location) <u>113 Schiller St</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>CAROLINE</u>	b. (Middle) <u>BARBARA</u>	c. (Last) <u>REBSAMEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>85-12-49</u>
-------------------------------------	----------------------------	----------------------------	---------------------------	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 26-1866</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
----------------------	-------------------------------	--	--------------------------------------	---	------------------------	-----------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <u>Berger, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
--	---	---	--

13a. FATHER'S NAME <u>Aug. Beckmann</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Danuser</u>	14. NAME OF HUSBAND OR WIFE <u>Frank A. Rebsamen</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Irma Spearman, Hermann, Mo</u>	ADDRESS <u>Mo</u>
--	-------------------------------------	--	-------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intestinal obstruction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Probable uterine malignancy</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>199R</u>	

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 1938, to 58-12, 1949, that I last saw the deceased alive on 58-11, 1949, and that death occurred at 9:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Howard Workman M.D.</u>	23b. ADDRESS <u>Hermann Mo</u>	23c. DATE SIGNED <u>5-14-49</u>
---	--------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>May 15-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hermann City</u>	24d. LOCATION (City, town, or county) (State) <u>Hermann, Mo</u>
---	------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>5/14/49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Hermann, Mo</u>
---	--	---	----------------------------

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

JUN 7 1949

Date Filed

~~JUN 7 1949~~

District File Number

District Health Officer No. 9

RECEIVED

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.....

Student Embalmer No.

.....
working under my personal supervision.

Signed.....

Jugost Oliver

Signed.....
Student Embalmer

Licensed Embalmer No. 3160

P. O. Address. *Mericaun 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.