

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33165**

NOV 10 1951

BIRTH NO. _____ REG. DIST. NO. 118 PRIMARY REG. DIST. NO. 5440 Registrar's No. 32

0370
1

1. PLACE OF DEATH a. COUNTY GASCONADE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MISSOURI b. COUNTY GASCONADE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL (CLAY TOWNSHIP)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL (CLAY TOWNSHIP) 0370	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) KARL CHARLES W b. (Middle) WITTE c. (Last) WITTE			4. DATE OF DEATH (Month) (Day) (Year) SEPT 16-1951		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug 29th 1887	9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	---	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming	10b. KIND OF BUSINESS OR INDUSTRY own farm	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	---

13a. FATHER'S NAME WILLIAM WITTE	13b. MOTHER'S MAIDEN NAME HELENA MEYERS	14. NAME OF HUSBAND OR WIFE (NEVER MARRIED)
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME William Witte ADDRESS Bland, Mo.
--	--	--

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Hemiplegia due to cerebral hemorrhage on hyperfensive basis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) None DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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)	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 9-10, 1951, to 9-16, 1951, that I last saw the deceased alive on 9-15, 1951, and that death occurred at 4:15A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paula Brant, M.D.	23b. ADDRESS Owensville, Mo.	23c. DATE SIGNED 9-17-51
---	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/17/51	24c. NAME OF CEMETERY OR CREMATORY Howard Cemetery	24d. LOCATION (City, town, or county) (State) Gasconade County, Mo.
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. Sept. 19, 1951	REGISTRAR'S SIGNATURE Barthel Hallace	FUNERAL DIRECTOR'S SIGNATURE Sassmann's Funeral Service-Bland	ADDRESS C. Bland
--	--	--	-------------------------

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

File No. _____
DISTRICT HEALTH OFFICE NO. 4

NOV - 8 1951

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.

Student
Student Embalmer

Signed Chuter Sorenson

Licensed Embalmer No. 4178

P. O. Address Bland - 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.