No. 300
10.48

FILED DEC 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41691

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 410

0143 2

1. PLACE OF DEATH
a. COUNTY: Calloway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
c. LENGTH OF STAY (In this place): 4 yr 8 m 29 d
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital No 1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Maries
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Belle 0630 1
d. STREET ADDRESS (If rural, give location): Unk

3. NAME OF DECEASED (Type or Print)
a. (First): Artie
b. (Middle): Mischa
c. (Last): Rethmeyer

4. DATE OF DEATH (Month) (Day) (Year): Dec 7 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 20 Oct 1874
9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months 1 Days 17
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and State or Foreign Country): Maries County Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Henry Scott
13b. MOTHER'S MAIDEN NAME: Jane Murphy Lan.
14. NAME OF HUSBAND OR WIFE: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT'S SIGNATURE OR NAME: State Hospital Records
ADDRESS: Fulton, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senile Psychosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia (Primary)

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 304X
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 March, 1948, *to* 7 Dec, 1952; *that I last saw the deceased alive on* 7 Dec, 1952, *and that death occurred at* 4:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. H. Fowler (G.S.W) (Degree or title) M.D
23b. ADDRESS: Fulton, Mo
23c. DATE SIGNED: 7 Dec 1952

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-10-52
24c. NAME OF CEMETERY OR CREMATORY: Liberty Cemetery
24d. LOCATION (City, town, or county) (State): Belle - Mo.

DATE REC'D BY LOCAL REG.: Dec-13-1952
REGISTRAR'S SIGNATURE: Maretta Lawrence
25. FUNERAL DIRECTOR'S SIGNATURE: Service
ADDRESS: Belle

(Licensed Embalmer's Statement on Reverse Side)

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

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 Chester Sassman

Licensed Embalmer No. 4178

P. O. Address BLAND

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.