

REC'D FEB 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1805
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
(b) Township 1 Primary Registration District No. 3008
(c) City Fulton Mo (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. St. Peters Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 26-1865

7. AGE YEARS 73 MONTHS 11 DAYS 21 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. USIC.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Co Mo

13. NAME Joseph T. Okmer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Anna Amerecin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Peters Mo

17. INFORMANT (ADDRESS) Records State Hospital No 1 Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL anatomical Bd
PLACE Columbia Mo DATE 1-26-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. O. Roberts Columbia Mo

20. FILED Jan 26, 1939 R. N. Crews Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 17 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 15 1938, to Jan 17 1939

I last saw him alive on Jan 17 1939 Death is said to have occurred on the date stated above, at 7:20 p.m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis

Other contributory causes of importance: ASC

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Chas. Washburn M. D.
(Address) State Hospital No 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.