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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 8910

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2393

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

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Illinois (b) County

(c) City or town O'Fallon N.R.
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MARTHA MAY WITTMER

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Walter

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

7. Birth date of deceased May (Month) 31 (Day) 1901 (Year)

8. AGE: Years 38 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Troy (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name JohnSapp

13. Birthplace Fayette Co. (City, town, or county) Illinois (State or foreign country)

14. Maiden name Martha Beam Blossom

15. Birthplace Bond Co. (City, town, or county) Illinois (State or foreign country)

16. (a) Informant John Sapp

(b) Address O'Fallon, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-13-40 (Month) (Day) (Year)

(c) Place: burial or cremation Troy, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAR 11 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 10 year 1940 hour 7:20 minute P. M.

21. I hereby certify that I attended the deceased from March 1, 1940, to March 10, 1940; that I last saw h. ~~ex~~ alive on March 10, 1940; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Hypertension, malignant | |
| Subarachnoid hemorrhage | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

28. Signature O M Anderson (M. D. or other)

Address BARNES HOSPITAL Date signed 3-11-40

(Licensed Embalmer's Statement on Reverse Side)

Used for
Purpose

## 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 Guy W. Wilkinson

Licensed Embalmer No. 2575

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.**