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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30101**

Registration District No. **7911**

Primary Registration District No. _____

Registrar's No. **7378**

REC'D OCT 25 1940

1. PLACE OF DEATH

(a) County Johnson
(b) City or town Johnson
(c) Name of hospital or institution Carroll City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3
(Specify whether _____)

In this community _____
years, months or days

8. (a) PRINT FULL NAME Albert Gutenberg

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color of race white 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years abt 72 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation Labourer

11. Industry or business _____

12. Name Unknown

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Nelson Norway P.D.
(b) Address 4312 S. ...

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director W. ...
(b) Address 3100 ...

19. (a) SEP 3 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town Johnson 23
(If outside city or town limits, write "RURAL.")
(d) Street No. 217 Carroll
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 17
year 1940 hour 1145 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Stenosis

Due to Coronary Artery Disease

Other conditions (Include pregnancy within 3 months of death) 105

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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury 5

23. Signature Joseph M. ...
Address ...

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

MOTHER FATHER

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.