

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.

FILED APR 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12361
Registrar's No. 2

Registration District No. 882

Primary Registration District No. 4535

1. PLACE OF DEATH:
 (a) County Warren
 (b) City or town Wright City, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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

3. (a) PRINT FULL NAME BERTHA-ANNA WOLTEMATH
 3. (b) If veteran, name was
 3. (c) Social Security No.
 4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 22 1873
 (Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days — If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name John Paul

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

14. Maiden name Angel Obermeyer (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature W. P. Gallenbach

(b) Address Wright City, Mo.

17. (a) Burial (b) Date thereof 3/25/41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright City, Mo

18. (a) Signature of funeral director Neuburg, Just & Co

(b) Address Wright City, Mo

19. (a) 3/25/41 (b) Julius Neuburg
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Warren
 (c) City or town Wright City, Mo
 (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

MEDICAL CERTIFICATION
 20. DATE OF DEATH, Month Dec day 22
 year 1941 hour 5 minute 30 P.M.
 21. I hereby certify that I attended the deceased from December 22, 1941 to March 22, 1941
 that I last saw him alive on March 22, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Sustained Hemorrhage Duration
 Due to _____
 Due to _____

Other conditions Hypertension
 (Include pregnancy within _____ months of death)
Myocarditis

Major findings:
 Of operations _____
 Of autopsy _____
 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?
0 _____ (Specify type of place)
 While at work _____ (e) Means of injury _____

23. Signature Phyl D. Killoran (M. D. or other) MD
 Address Wright City, Mo Date signed 3/25/41

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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, *X*.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Julius J. Beeburg*
Licensed Embalmer No. *3868*
P. O. Address *Wright City 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 882

Primary Registration District No. 4535

Registrar's No. _____

1. PLACE OF DEATH

(a) County Warren City Mo.
(b) City or town Wright City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(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 _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bertha Anna Voltemath
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH Month Mar day 22
year _____ hour _____ minute _____ M.

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Gastric Remorose (Indicate location)

8. AGE: Years 69 Months 3 Days _____
If less than one year _____ hr. _____ min.

Due to Gastric Tuberculosis
Due to _____

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

Other conditions Hypertension
(Include pregnancy within 6 months of death)

10. Usual occupation _____

Major findings: Myocarditis

11. Industry or business _____

12. Name _____

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 _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

Of autopsy _____

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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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

MOTHER FATHER

Registration District No. 882

Primary Registration District No. 45-35

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Warren

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

(c) Name of hospital or institution: _____
(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 MO (b) County Warren

(c) City or town Wright City
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country: _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bertha Anna Woltemath

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

20. DATE OF DEATH: Month Mar. day 22
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that he/she was _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased: Dec 22 1873
(Month) (Day) (Year)

Immediate cause of death
Gastric Hemorrhage
Gastro-enteritis Ca

Due to Staphylococcus

Due to _____

8. AGE: Years 67 Months 3 Days _____ If less than one day _____ min.

Other conditions Hypertension
(Include pregnancy within 3 months of death)
Myocarditis

Major findings: Of operations no operation

Of autopsy no autopsy

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

10. Usual occupation Wife

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

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 _____

23. Signature J. P. Kellorau (M. D. or other) _____
Address Wright City, MO Date signed 12/24/41

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

SUPPLEMENTAL

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

MOTHER FATHER