DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 18 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28852

Registration District No. 548 Primary Registration District No. 5740 Registrar's No. 30

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

1. PLACE OF DEATH:

(a) County: Marion

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

(c) Name of hospital or institution: Infirmary 5 (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Marion 64

(c) City or town: Palmyra 0 (If outside city or town limits, write "RURAL")

(d) Street No.: Infirmary 0 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No) If yes, name country .....

3. (a) PRINT FULL NAME: Frank Ketterer

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Alice

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

7. Birth date of deceased: Feb. (Month) 21 (Day) 1866 (Year)

8. AGE: Years 75 Months 6 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace: Germany 4 (City, town, or county) (State or foreign country)

10. Usual occupation: LaBoRer

11. Industry or business .....

FATHER

12. Name: Frank Ketterer

13. Birthplace: Germany 4 (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Pauline Fielder

15. Birthplace: Germany 4 (City, town, or county) (State or foreign country)

16. (a) Informant: J. Ketterer

(b) Address: 508 Olive - Hannibal, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/9/41 (Month) (Day) (Year)

(c) Place: burial or cremation: Mount Olivet - Hannibal, Mo.

18. (a) Signature of funeral director: Crawford Smith

(b) Address: 902 Broadway - Hannibal, Mo.

19. (a) Sept 9-1941. (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7 year 1941 hour 2:00 minute P M.

21. I hereby certify that I attended the deceased from Sept 2 1941 to Sept 7 1941; that I last saw h... alive on Sept 7 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerosis — Myocardial degeneration.	
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 .....

23. Signature: H. E. Sicker (M. D. or other) MD

Address: Hannibal Mo. Date: Sept 8-41

(Licensed Embalmer's Statement on Reverse Side)

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 James A Moleo

Licensed Embalmer No. 3296

P. O. Address Hannibal Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
—8-21-41
PI X29288

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(b) City or town: Palmyra
(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 years, months or days)
In this community

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: Frank Ketterer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

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 years

7. Birth date of deceased: Feb. (Month) 21 (Day) 1866 (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Sept. 9-1941 (Date received local registrar) (b) Gertrude Lee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day

year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw him alive on 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY