DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1942

Registration District No. 792

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3753

Primary Registration District No. 4473 6029

Registrar's No.

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

1. PLACE OF DEATH

(a) County: Saline

(b) City or town: Marshall R.F.D. 7 Box A
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Farm Rock Island Rural
(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 31 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Saline 97

(c) City or town: Napton R.F.D. 1 Box (If outside city or town limits, write "RURAL") C3

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Josephine M. Waterman

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Robt. Waterman

6. (c) Age of husband or wife if alive: 62 years

7. Birth date of deceased: July (Month) 8 (Day) 1880 (Year)

8. AGE: Years 61 Months 6 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace: Montgomery Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: Home Keeper

11. Industry or business: ✓

FATHER
12. Name: William Brew
13. Birthplace: Germany 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Margaret Thurmeyer
15. Birthplace: Germany 4 (City, town, or county) (State or foreign country)

16. (a) Informant: Robert Waterman
(b) Address: Napton Mo. RFD 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 13-1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Farm Rock Cem

18. (a) Signature of funeral director: Sampley-Lewis
(b) Address: Marshall Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10th year 1942 hour 9 minute a M.

21. I hereby certify that I attended the deceased from Dec. 29, 1941, to Jan 10, 1942 that I last saw her alive on Jan. 10, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchio Pneumonia	12 days
Due to	
Due to	
Other conditions: Bright's disease chronic (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ✓
Of autopsy: No

107

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: C. L. Lawler (M. D. or coroner) 0
Address: Marshall Mo. Date signed 1-10-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number .....

Date Filed 2-13-42

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 Jas. H. Lewis

Licensed Embalmer No. 1171

P. O. Address Marshall 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3753

Registration District No. 792 Primary Registration District No. 6035 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Rural
(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 Josephine M Kateman
3. (b) If veteran, name war
3. (c) Social Security No.

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 years
7. Birth date of deceased July 8 1880 (Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Jan 12 (Date received local registrar) (b) 42 C. L. Lawless (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 19 year 1942 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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (c) Means of injury

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

SUPPLEMENTARY