No. 2
4-13-40
5-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 12 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

42181

State File No.

Registration District No. 328 Primary Registration District No. 6112 Registrar's No. 200

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Chaffee
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. #1
(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 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Chaffee Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Anthony Westrich
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Aug. (Month) 14 (Day) 1876 (Year)
8. AGE: Years 66 Months 4 Days 2 If less than one day hr. min.
9. Birthplace New Hamburg (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farming
11. Industry or business Farmer
MOTHER FATHER
12. Name Phillip Westrich
13. Birthplace no record (City, town, or county) Germany (State or foreign country)
14. Maiden name Mary Forde
15. Birthplace no record (City, town, or county) Germany (State or foreign country)
16. (a) Informant Mrs. Katie Bucher
(b) Address New Hamburg Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-42 (Month) (Day) (Year)
(c) Place: burial or cremation New Hamburg Mo
18. (a) Signature or funeral director [illegible]
(b) Address Chaffee Mo
19. (a) 12-17-1942 (Date received local registrar) (b) Mrs. A. H. Davis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16 year 1942 hour 6 minute P M.
21. I hereby certify that I attended the deceased from dec 15, 1942, to Dec 16, 1942 that I last saw h alive on October, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	10 Days
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 W. O. Finney M.D. (M. D. or other)
Address Chaffee Mo Date signed 12/17/42

108 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 143 — 71
Date Filed 1-7-43

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 wi the above constitutes grounds for revocation of license.)

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