

No. 2
4-13-40
1-17-39
X23152

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15646

FILED MAY 7 1943

Registration District No. 322

Primary Registration District No. 3073-R-6112

Registrar's No. 8

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

1. PLACE OF DEATH:

(a) County Scott

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

(c) Name of hospital or institution: 1 Kelsa Camp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 84 yrs, 5 mos, 28 days (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 100

(a) State Missouri (b) County Scott

(c) City or town Moreland - "rural"
(If outside city or town limits, write "RURAL")

(d) Street No. Leo Blattel Farm - Chaffee Mo. Rt #1
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME John Morie

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
year 1943 hour 9 minute 25 A.M.

21. I hereby certify that I attended the deceased from 3-29, 1943 to 4-8, 1943

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, 2 divorced widowed

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

7. Birth date of deceased. Oct. 10 1943
(Month) (Day) (Year)

that I last saw him alive on March 29, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Decompensation

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

<u>84</u>	<u>5</u>	<u>28</u>	hr. _____ min. _____
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Due to Aortic Stenosis and regurgitation

Due to _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

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

Major findings: 97W
Of operations _____

Of autopsy _____

MOTHER FATHER { 12. Name Marcus Morie

13. Birthplace Alsace-Lorraine
(City, town, or county) (State or foreign country)

14. Maiden name Link

15. Birthplace Unknown
(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 M. P. Bregan (M. D. or other) D.O.
Address Benton, Mo. Date signed 4-8-43

16. (a) Informant Pete Morie

(b) Address Chaffee, Mo. Rt #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19 1943
(Month) (Day) (Year)

(c) Place: burial or cremation New Hamburg, Mo.

18. (a) Signature of funeral director Bisplinghoff & Hubbars

(b) Address Chaffee, Mo

19. (a) 4-9-43 (Date received local registrar) (b) Christa Gravel (Registrar's signature)

RECEIVED

District Health Office No. 2

District File Number 543-60

Date Filed 5-6-43

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 Marnie Burdick Jeff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.