

Registration District No. **19429**

Primary Registration District No. **4170**

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

32
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1. PLACE OF DEATH:

(a) County **DeKalb**

(b) City or town **Union Star 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 **40. Yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **DeKalb.**

(c) City or town **Union Star Mo.**
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME **Rosa Cathryn Theis.**

3. (b) If veteran, name war **No.**

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

4. Sex **Female.** 5. Color or race **Gau.** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **William C.** 6. (c) Age of husband or wife if alive **59.** years

7. Birth date of deceased **12.** **3.** **1882**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	6	4	hr. _____ min.

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

10. Usual occupation **Housework.**

11. Industry or business _____

12. Name **David Blosser.**

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

14. Maiden name **Fannie S. Varner.**

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

16. (a) Informant **W.C. Theis.**

(b) Address **Union Star Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6.9.1; 143.**
(Month) (Day) (Year)

(c) Place: burial or cremation **Union Star Mo.**

18. (a) Signature of funeral director **R.H. Taggart**

(b) Address **King City Mo.**

19. (a) **6-21-43** (Date received local registrar) (b) **C. M. Dingley** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **7** year **1943** hour **9** minute **15.A.M.**

21. I hereby certify that I attended the deceased from **May 19** 19**43** to **June 7** 19**43** that I last saw **her** alive on **July 5** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis** Duration **10 days**

Due to **Streptococcus Infection Throat** **20 days**

Other conditions (Include pregnancy within 3 months of death) **93e!**

Major findings: Of operations _____

Of autopsy _____

Duration

10 days

20 days

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **E. W. Reynolds** (M. D. or other) **6-8-43**

Address **Union Star Mo.** Date signed _____

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 *R. G. Taggart*.....

Licensed Embalmer No. 2563.....

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