DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24773

ED JUL 27 19[illegible]

Registration District No. 84

Primary Registration District No. 5319

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Otterville Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution near 1 Clifton City Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether
In this community 60 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 27

(a) State ..... (b) County 0

(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 0

3. (a) PRINT FULL NAME GEORGE-VEST-STREIT.

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Sadie Street

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Aug-12-1882 (Month) (Day) (Year)

8. AGE: Years 60 | Months 10 | Days 19 | If less than one day ✓ hr. ✓ min.

9. Birthplace Cooper Co - Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Same

FATHER
12. Name John A. Streit
13. Birthplace Unknown Va. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Louisa Skaggs
15. Birthplace Benton Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Frank B. Streit
(b) Address Otterville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July-3-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Hays + Painter
(b) Address Pilot Grove, Mo

19. (a) July 6-1943 (Date received local registrar) (b) Mrs W W Robien (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1st day July year 1943 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan 1-1942, 19..., to July 1, 1943 that I last saw him alive on June 30 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary T.B.	4 yrs
Due to ✓	
Due to ✓	
Other conditions ✓ (Include pregnancy within 3 months of death)	

Robt Fogle

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 Robt Fogle (M. D. or other)
Address Otterville Mo Date signed July 2 1943

1087

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
JUL 27 1943
District File Number
Date Filed 7-23-43

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 Peyton E. Hay

Licensed Embalmer No. 3074

P. O. Address Pilot Grove

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 84 Primary Registration District No. 5319 Registrar's No. AUG - 1943

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Otterville Twp.
(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 Mo (b) County Cooper

(c) City or town Near - Clifton City
(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 George West Streit

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 Aug (Month) 12 (Day) 1883 (Year)

8. AGE: Years 60 Months 10 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Mo. (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) _____ (Date received local registrar) (b) Mrs. Rev. Robison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h. _____ alive on _____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

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

5-24773