

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32701

FILED SEP 16 1943

Registration District No. 1043

Primary Registration District No. 5655

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Warren
(b) City or town St. Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26.31 days
(Specify whether years, months or days) 26.31 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town La Clede
(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 Dorothy Kramer

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

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

7. Birth date of deceased Aug 25 1908
(Month) (Day) (Year)

8. AGE: Years 35 Months 0 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace La Clede Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business _____

12. Name Chas. T. Sharpe

13. Birthplace Marion Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Rosa B. West

15. Birthplace Magnolia Ia
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Michael Beard Clerk

(b) Address Mo State San. St. Vernon Mo

17. (a) Removal (b) Date thereof Sept 9 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Mo

18. (a) Signature of funeral director Geo. W. Orr

(b) Address Mr. Vernon Mo

19. (a) 9/11/43 (b) W. D. Crawford
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9 year 1943 hour 9 minute 15 A.

21. I hereby certify that I attended the deceased from June 26 to Sept 9, 1943 that I last saw her alive on Sept 9, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis abt 1942

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 13 f. l.

Major findings: Of operations _____

Of autopsy _____

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 A. B. Stocker (M. D. or other) _____

Address Mr. Vernon Mo Date signed 9/9/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6;

District File Number 943-1078

Date Filed 9-14-43

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 Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address Mr. Vernon Ho

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.