

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

NOV 9 1943
X33897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35354

State File No. _____

Registration District No. 234

Primary Registration District No. 5815

Registrar's No. 21

1. PLACE OF DEATH:
 (a) County Morgan
 (b) City or town Rural Hawcreek 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)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Morgan 071
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 8 mi. N.E. Stover
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Carline Willmer
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct. day 9 th.
 year 1943 hour 7 minute 55 A.M.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Oscar Willmer
 6. (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased Feb. 8, 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 12, 1943 to Oct 9, 1943
 that I last saw her alive on Oct 8, 1943
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
76 8 1 hr. _____ min.
 9. Birthplace Germany
(City, town, or county) (State or foreign country)

Immediate cause of death
Sarcoma - melanotic type, left abdominal wall & pleural complication
 Due to _____
 Due to _____

10. Usual occupation House wife
 11. Industry or business _____
 MOTHER FATHER { 12. Name Frederick Mestmecker
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Louise Heismeyer
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

16. (a) Informant Henry Willmer
 (b) Address Versailles, Mo.
 17. (a) Burial (b) Date thereof Oct. 11, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Nolting Cem.
 18. (a) Signature of funeral director Rapp & Stevinson
 (b) Address Stover, Mo.
 19. (a) Oct 30 43 (b) Henry Rapp
(Date received local registrar) (Registrar's signature)

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 A. J. Gunn (M. D. or other) _____
 Address Versailles Mo Date signed 10/10/43

JUL 21 1948

RECEIVED

District Health Officer No. 7,

Case No. Number 10-43-1196

Date Filed 11-8-43

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 Jewell Stevenson
Licensed Embalmer No. 4073
P. O. Address Stover, 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.

Nov

Registration District No. 234

Primary Registration District No. 5-815-

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Rural Haw Creek 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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Carline Willmer

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

4. Sex F 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 Feb 8 1943
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days _____ (Unless than one day) min. _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

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) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 9 Year 1943
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Sarcoma Duration 2 yrs
metastatic
left abdominal wall
plurial complication

Due to _____

Due to Primary seat embolism

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____ 552
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? _____

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

23. Signature Ray Swan (M. D. _____)
Address Berkeley Mo Date signed 11-11-43

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

SUPPLEMENTARY

35354

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