DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3597

Registration District No. 215 Primary Registration District No. 4327 Registrar's No.

1. PLACE OF DEATH:
(a) County: Miller
(b) City or town: Iberia (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gould's Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Miller 66
(c) City or town: ✓ (If outside city or town limits, write "RURAL") 0
(d) Street No.: ✓ (If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country: ✓

3. (a) PRINT FULL NAME: JUDY ANNA OTTO
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Fem
5. Color or race: White
6. (a) Single, widowed, married, divorced: S-0
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: Jan (Month) 13 (Day) 44 (Year)
8. AGE: Years | Months | Days 5 | If less than one day hr. min.
9. Birthplace: Iberia (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation: —
11. Industry or business: —
12. FATHER Name: Martin Otto
13. FATHER Birthplace: St Elizabeth (City, town, or county) Mo 0 (State or foreign country)
14. MOTHER Maiden name: Victoria Schaffer
15. MOTHER Birthplace: Meta (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant: Marty Otto
(b) Address: St Elizabeth Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-44 (Month) (Day) (Year)
(c) Place: burial or cremation: St Antony
18. (a) Signature of funeral director: C. Carey
(b) Address: Iberia, Mo
19. (a) Jan. 20-44 (Date received local registrar) (b) Jessie Perkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18 year 1944 hour 1 minute P M.
21. I hereby certify that I attended the deceased from Jan 13, 1944, to Jan 18, 1944; that I last saw her alive on Jan 18, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature birth	5 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 159	
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: Wm. A. Gould (M. D. or other) D.O.
Address: Iberia Mo Date signed 1/19/44

1717 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
Miller County Health Dep't.
County File Number 44-14
Date Filed 1-7-44

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.

No Embalming

Signed C R Casey

Licensed Embalmer No. 7694

P. O. Address Iberia, Mo

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

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

o. 2B
-5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County Miller

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

(c) Name of hospital or institution: Goulds Hosp.
(If not in hospital or institution, write street number or location).

(d) Length of stay: In hospital or institution 5 da (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller

(c) City or town Rural - Osage Township
(If outside city or town limits, write "RURAL")

(d) Street No. Meta, Mo.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Judy A. Otto

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 S

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

7. Birth date of deceased Jan. (Month) 13 (Day) 94 (Year)

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

9. Birthplace ..... (City, town, or county) Mo. (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) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 18
year 1944 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.

	Duration
Immediate cause of death	
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

3597