

FILED MAY 9 1944

Registration District No. 178

Primary Registration District No. 5439

Registrar's No. 83

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town RURAL CANAAN TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OWENSVILLE ROUTE 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 53 YEARS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE 37
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. OWENSVILLE ROUTE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CATHERINE SCEGO.

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED.

6. (b) Name of husband or wife THOMAS SCEGO, SR. 6. (c) Age of husband or wife if alive DEAD years

7. Birth date of deceased NOVEMBER 25 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 5 4 - hr. - min.

9. Birthplace OBERSLABEN GERMANY 4
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE.

11. Industry or business

12. Name FRANK RAPIER
13. Birthplace NOT KNOWN UNKNOWN 4
(City, town, or county) (State or foreign country)
14. Maiden name NOT KNOWN
15. Birthplace - UNKNOWN 4
(City, town, or county) (State or foreign country)

16. (a) Informant JOSEPH SCEGO
(b) Address OWENSVILLE, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 2 1944
(Month) (Day) (Year)
(c) Place: burial or cremation OWENSVILLE CATHOLIC CEM.

18. (a) Signature of funeral director Myrtle M. Wankel
(b) Address Owensville Mo.

19. (a) May 2 1944 (b) Myrtle M. Wankel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 29
year 1944 hour 4 minute 40 A. M.

21. I hereby certify that I attended the deceased from June 1942 to 4 - 29 1944
that I last saw 24 alive on 4 - 25 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (hypostatic) 4 days
Due to Chronic Encephalitis (Post)

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?

While at work? _____ (Specify type of place) Means of injury 0
23. Signature Chas A Johnson (M. D. or other)
Gene C Mo Date signed 5-1-44

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-8-44

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 Me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Welford H. H. Winter
Licensed Embalmer No. 3838
P. O. Address Quenerville 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.

Registration District No. 118 Primary Registration District No. 5429

1. PLACE OF DEATH:

(a) County Goschenade

(b) City or town Rural Cassan Supp
(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 Catherine Srega

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 _____

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

7. Birth date of deceased Nov. 25 1906
(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days _____ If less than one day _____ min.

9. Birthplace Germany
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 April 29
year 1948 hour _____ minute _____ M.

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

Immediate cause of death Pneumonia
Hypostatic
Lobar

Due to Chronic Encephalitis (Par)

Due to _____

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

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration _____

Physician 108

Underline the cause to which death should be charged statistically.

14622

Steward, M. O.

Schmidt

Dr. Chan A.