

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 9 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14624

State File No. _____
Registrar's No. _____

Registration District No. 117

Primary Registration District No. 5436

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town RURAL BOURBON 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 ENTIRE LIFE. years, months or days

3. (a) PRINT FULL NAME MARY SOPHIA WITTE

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

4. Sex FEMALE 3. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased DECEMBER 3 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 4 18 hr. min.

9. Birthplace BAV MO. O
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business

12. Name Fritz Witte
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name MARY LANDWEHR
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant LOUIS WITTE

(b) Address BAV MO.

17. (a) BURIAL (b) Date thereof 4 24 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ZION'S EX. CEM. BAV MO.

18. (a) Signature of funeral director Myford N. Winter

(b) Address Owensville Mo.

19. (a) 4-24-44 (b) Mrs. F. B. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE
(c) City or town RURAL 37
(If outside city or town limits, write "RURAL")

(d) Street No. NEAR BAY 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 21
year 1944 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from 1-15- 1943, to 4-21- 1944
that I last saw her alive on 4-21- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular
Collophyl
Due to Chronic Nephritis
General Dropsy
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?

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

23. Signature Howard Harkman (M. D. or other) _____
Address Hermann Mo. Date signed 4-24-44

1262 (Licensed Embalmer's Statement on Reverse Side)

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.....

Michael Winters

Licensed Embalmer No. 3838

P. O. Address Owensville, Ind.

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.