

FILED MAY 27 1944
Registration District No. **1558**

Primary Registration District No. **5921**

1. PLACE OF DEATH: Pettis Rual
(a) County Pettis Rual
(b) City or town (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 **7 Years** (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Pettis 80**
(c) City or town **Rual 7** (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Johanna M. Viebrock**
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 **Henry Viebrock** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **Dec 30 1875** (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **4** day **22** 44
year **11** hour **P** minute **44** M.
21. I hereby certify that I attended the deceased from **4-14** 19**44** to **4-22** 19**44**
that I last saw her alive on **4-22** 19**44**
and that death occurred on the date and hour stated above.

8. AGE: Years **68** Months **3** Days **22** If less than one day
hr. min.

Immediate cause of death **Coronary disease**
Due to **arterial degeneration** ?
Due to
Other conditions **Chronic myocarditis** ?
(Include pregnancy within 3 months of death)

9. Birthplace **St Charles Co Mo.** (City, town, or county) (State or foreign country)
10. Usual occupation **House Wife**

PHYSICIAN
Major findings:
Of operations **93d**
Of autopsy **no**
Underline the cause to which death should be charged statistically.

11. Industry or business
12. Name **Henry J. Detmer**
13. Birthplace **St Charles Co Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Henrietta Foss**
15. Birthplace **St Charles Co Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Henry Viebrock,**
(b) Address **Sweet Springs Mo.**
17. (a) (Burial, cremation, or removal) **Burial** (b) Date thereof **4-25-44** (Month) (Day) (Year)
(c) Place: burial or cremation **Slater Mo.**
18. (a) Signature of funeral director **B.F. Parker**
(b) Address **La Monte Mo.**
19. (a) (Date received local registrar) **4-29-44** (b) **Mrs Anna Berger** (Registrar's signature)

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 **J. H. Hale** (M. D. or other) **D.O.**
Address **Sweet Springs Mo.** Date signed **4-26-44**

Health Officer
Date Filed 5-5-44
Date Filed

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..... *B. J. Cannon*

Licensed Embalmer No. 1592

P. O. Address..... *La Mor*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 144

Registration District No. 274 Primary Registration District No. 5921

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Rolla Rural
(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 Johanna M. Viebrock
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 _____ min.
7. Birth date of deceased Dec 30
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 15 If less than one day _____ min.
9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 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)

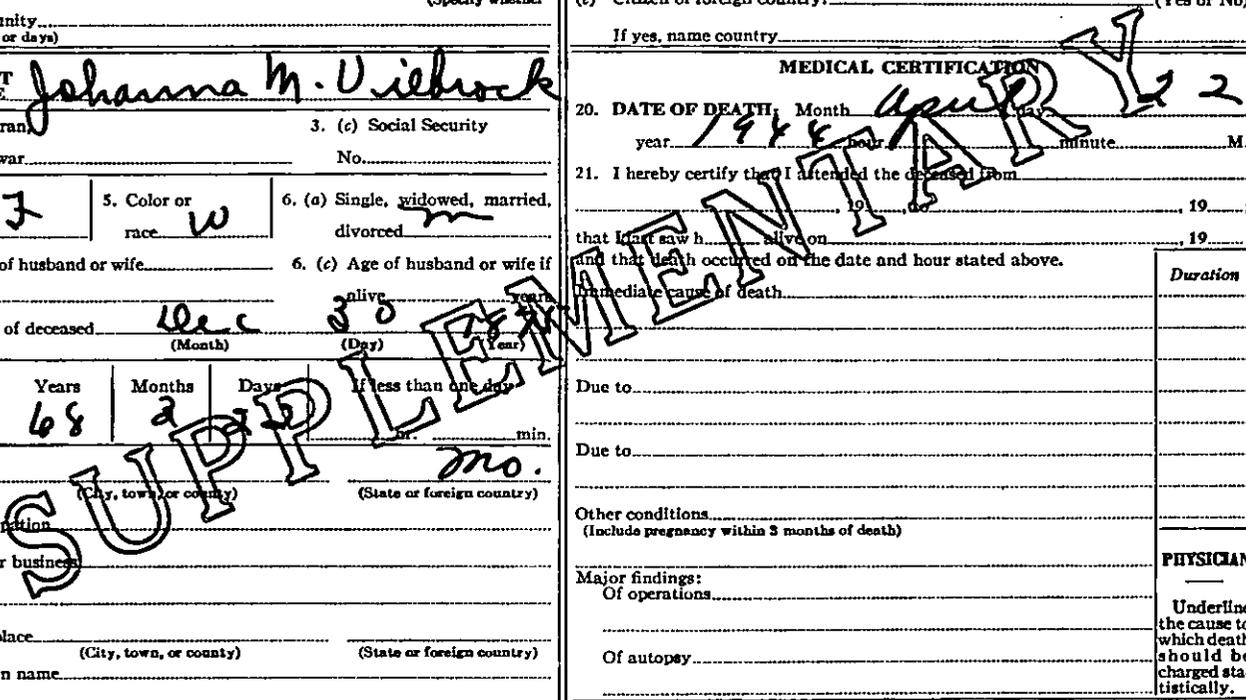
16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

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 year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
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 _____



Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

15443