

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20810

FILED JUL 8 1944
Registration District No. *1002*

Primary Registration District No. *1002*

State File No. _____

Registrar's No. *2626*

1. PLACE OF DEATH:

(a) County *Jackson*
(b) City or town *Keokuk*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3329 Wyandotte
(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 *unk. 1*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Jackson*
(c) City or town *Ke*
(If outside city or town limits, write "RURAL")
(d) Street No. *3329 Wyandotte*
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *ROSE PITZER*
(b) If veteran, *no* name war _____
(c) Social Security No. *None*

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *6* day *22*
year *44* hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from *June 5th*
_____ 19*44*, to *June 12th* _____ 19*44*;
that I last saw her alive on *June 12th* 19*44*
and that death occurred on the date and hour stated above.

4. Sex *1* Color or race *w.*
5. (a) Single, widowed, married, *divorced*
(b) Name of husband or wife *Mike* (c) Age of husband or wife if alive *Deceased*
7. Birth date of deceased *Dec 25, 1878*
8. AGE: Years *65* Months *5* Days *27*
If less than one day _____ hr. _____ min.

Immediate cause of death: *Acute Coronary insufficiency*
Arteriosclerotic heart
Disease
Other conditions (include pregnancy within 3 months of death) *93 d*

9. Birthplace *Unknown* (City, town, or county) _____ (State or foreign country) _____
10. Usual occupation *Retired - 5 yrs*
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) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations _____
Of autopsy *History*

MOTHER FATHER {
16. (a) Informant *Mrs Gailie Finney*
(b) Address *3329 Wyandotte*
17. (a) *Burial* (burial, cremation, or removal) (b) Date thereof *6-24-44*
(Month) (Day) (Year)
(c) Place: burial or cremation *St Marys Cemetery*
18. (a) Signature of funeral director *R. W. Tobin*
(b) Address *2020 Jewwood*
19. (a) *6-22-44* (Date received local registrar) (b) *T. E. Brown* (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) _____
Means of injury _____
23. Signature *A. E. Upoker* (M. D. or other) *M.D.*
Address *281 Moley* Date signed *6/25*

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.