

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25353

State File No. _____

FILED JUL 24 1944
Registration District No. _____

Primary Registration District No. 5881

Registrar's No. _____

1. PLACE OF DEATH:

(a) County OSAGE
(b) City or town RURAL "JEFFERSON 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 29 YEARS. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County OSAGE 76
(c) City or town RURAL (BELLE MO.)
(If outside city or town limits, write "RURAL")
(d) Street No. JEFFERSON TWP.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CATHARINA SOPHIE PUVOGEL

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 HENRY PUVOGEL 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPTEMBER 12 1848
(Month) (Day) (Year)

8. AGE: Years 95 Months 8 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

12. Name FREDERICK WIKKE

13. Birthplace HANOVER 4 GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name ANNA PUVOGEL

15. Birthplace HANOVER 11 GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. ROSA DREWELL

(b) Address COLLINSVILLE, OKLA.

17. (a) BURIAL (b) Date thereof MAY 21 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FEARSVILLE CEM.

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

(b) Address Edenville Mo.

19. (a) 5/22/1944 (b) Eduard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 18 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 5-9-44 to 5-18, 1944, that I last saw her alive on 5-17, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompression With Dilatation Duration 1 wk

Due to Hypertension 3 yrs.

Due to Atherosclerosis, Advanced 3 yrs.

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) (e) Means of injury _____

23. Signature Paul A. Brewster (M. D. or other)

Address One mile, Mo. Date signed 5-19-44

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

7600

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-22-44

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 Malcolm H. Winter

Licensed Embalmer No. 3838

P. O. Address Owensville 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.