

No. 2
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5-17-39
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D.A. J.C. McClure

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28922

State File No. _____

Registrar's No. _____

FILED AUG 17 1944

Registration District No. 333

Primary Registration District No. 1015

1. PLACE OF DEATH:

(a) County: Rural Scott

(b) City or town: Richardson

(c) Name of hospital or institution: Residence

(d) Length of stay: In hospital or institution: 4 years

In this community: 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: New Madrid

(c) City or town: Rural

(d) Street No.: 8 Miles Northeast of E. Paris, Mo.

(e) Citizen of foreign country? No.

If yes, name country: 1

3. (a) PRINT FULL NAME: THOMAS JEFFERSON UTHOFF

3. (b) If veteran, name war: ✓ 3. (c) Social Security No.: None

4. Sex: M. 5. Color or Race: W. 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Irene Uthoff 6. (c) Age of husband or wife if alive: 55 years

7. Birth date of deceased: June 11, 1885

8. AGE: Years: 59 Months: 1 Days: 8 If less than one day: _____ hr. _____ min.

9. Birthplace: Mississippi Co. Mo.

10. Usual occupation: Farming

11. Industry or business: Henry Uthoff

12. Name: Cincinnati, Ohio

13. Birthplace: Cincinnati, Ohio

14. Maiden name: Madeline Angeline Dupont

15. Birthplace: Metropolis, Illinois

16. (a) Informant: Fred A. Uthoff

(b) Address: Commerce, Mo.

17. (a) Rural (b) Date thereof: July 21, 1944

(c) Place: burial or cremation: Deerwood

18. (a) Signature of funeral director: David Shelly

(b) Address: East Paris, Mo.

19. (a) _____ (b) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 19th year: 1944 hour: 3 minute: P. M.

21. I hereby certify that I attended the deceased from 8-31 1944 to 7-19 1944

that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Interval Apoplexy

Due to: _____

Due to: _____

Other conditions: Idemplogia

Major findings: 83d

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? _____

(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: 0

23. Signature: D. J. C. McClure (M.D. or other) _____

Address: Dikeaton, Mo. Date signed: 7-29-44

Duration: 24 hrs.

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

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

1318

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 844-1157

Date Filed 8-16-44

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.....

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

Signed

Travis Shelby

Licensed Embalmer No.

2726

P. O. Address

East Prairie, M.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept.

Registration District No.

333

Primary Registration District No.

3074

Registrar's No.

1. PLACE OF DEATH:

- (a) County *Scott*
- (b) City or town *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 _____ (Specify whether
years, months or days) *4 w.*

3. (a) PRINT FULL NAME

Thomas J. Utzogg

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

- 4. Sex *m* 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 *33* years

- 7. Birth date of deceased *June 11 - 1951*
(Month) (Day) (Year)

- 8. AGE: Years *59* Months _____ Days _____ (If less than one day) _____ min.

- 9. Birthplace _____ (City, town, or county) (State or foreign country)

- 10. Usual occupation *Farming*

- 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) *10-11-44* (b) *Leinie Largent*
(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 *July* Day *17* Year *1944* Minute _____ M. *59*

- 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 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) (c) Means of injury _____

- 23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

28922