

S. No. 2
M-9-4-41
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30620**
Registrar's No. **290**

Registration District No. **47**

Primary Registration District No. **3008**

1. PLACE OF DEATH: *Callaway*
(a) County *Callaway*
(b) City or town *Fulton*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: *State Hosp # 1* **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *Since 6-27-1944*
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State *Missouri* (b) County *Osage 14*
(c) City or town *Keetztown* **1**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Elnore Sandbriker Otto*
3. (b) If veteran, name war _____
3. (c) Social Security No. *Separated*

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *Sept* day *5* year *1944* hour *5* minute *40 A.M.*
21. I hereby certify that I attended the deceased from *June 27*, 1944, to *Sept 5*, 1944 that I last saw her alive on *Sept 4*, 1944 and that death occurred on the date and hour stated above.

4. Sex *Female* 5. Color or race *white*
6. (a) Single, widowed, married, divorced *Separated*
6. (b) Name of husband or wife *Ben Otto*
6. (c) Age of husband or wife if alive *37* years
7. Birth date of deceased *July 26 1909*
(Month) (Day) (Year)

Immediate cause of death *Syphilitic meningitis encephalitis (Parasitic)*
Due to _____
Due to _____

8. AGE: Years *35* Months *1* Days *9*
If less than one day hr. _____ min. _____

Other conditions *agitated mental disturbance with manure decubitus ulcers*
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace *Osage Co. Mo. (1)*
(City, town, or county) (State or foreign country)
10. Usual occupation *Housewife*

11. Industry or business _____
12. Name *Frank Sandbriker*
13. Birthplace *Keetztown Mo. (1)*
(City, town, or county) (State or foreign country)
14. Maiden name *Elizabeth Blasse*
15. Birthplace *Keetztown Mo. (1)*
(City, town, or county) (State or foreign country)

16. (a) Informant *incomplete Hosp. records*
(b) Address _____
17. (a) *Buried* (b) Date thereof *9-8-44*
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director *Monte General Home*
(b) Address *Osage Mo*
19. (a) *7-5-1944* (b) *Josee Morantoff*
(Date received local register) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury *fall*
23. Signature *P. S. Tate* (M. D. or other)
Address *State Hosp # 1 of Fulton* Date signed *9-8-44*

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 10-5-44

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 Victor Buescher

Licensed Embalmer No. 3701

P. O.-Address Jefferson City, 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.