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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 8 1944
319

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38907

State File No. _____

Registration District No. 319

Primary Registration District No. 6079

Registrar's No. 60

1. PLACE OF DEATH:

(a) County. STE. GENEVIEVE

(b) City or town. RURAL STE. GENEVIEVE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: COUNT HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 35 years
(Specify whether)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. STE. GENEVIEVE

(c) City or town. RURAL 95
(If outside city or town limits, write "RURAL")

(d) Street No. St. Genevieve Twp. 0
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country. 1)

3. (a) PRINT FULL NAME KATIE BOBE

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

20. DATE OF DEATH: Month Nov day 22
year 1944 hour 7:30 minute A.M.

21. I hereby certify that I attended the deceased from Oct 16
1944 to Nov 22 1944
that I last saw her alive on Nov 20 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. SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. UNKNOWN 1882
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis ?
Duration

8. AGE: Years 62 Months unknown Days _____ If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions Fracture of Right Hip 10/16/44
(Include pregnancy within 3 months of death)

9. Birthplace STE. GENEVIEVE MO.
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business _____

MOTHER FATHER

12. Name PETER BOBE

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

14. Maiden name MARY BOBE

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant COUNTY FARM RECORDS

(b) Address STE. GENEVIEVE MO

17. (a) BURIAL (b) Date thereof 11-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STE. GENEVIEVE MO

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 _____

18. (a) Signature of funeral director H. E. Basler

(b) Address St. Genevieve Mo

19. (a) Nov. 23/44 (b) T.W. Douglas
(Date received local registrar) (Registrar's signature)

23. Signature St. Genevieve Mo (M. D. seal)
Address St. Genevieve Mo Date signed 11/23/44

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

505

RECEIVED

District Health Officer No. 4

District File Number 1244-462

Date Filed 12-7-44

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 *Lea C. Basler*

Licensed Embalmer No. 1985

P. O. Address *St. Genevieve 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. dlc
Registrar's No. 60

Registration District No. 319

Primary Registration District No. 6079

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

1. PLACE OF DEATH:

(a) County St. Genevieve

(b) City or town Rural St. Genevieve
(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 years, months or days)

3. (a) PRINT FULL NAME Katie Buhe

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 5

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive.....

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years 62 Months Days no. (If less than one day) min.

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

10. Usual occupation.....

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)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (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 Sept 22
year 1944 hour 12 minute 00 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 Chronic Myocarditis

Due to.....

Due to Fracture of Right Hip
(fall at home) 9-29-44

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: 186a

Of operations.....

Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident

(b) Date of occurrence Sept 29, 1944

(c) Where did injury occur? St. Genevieve Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Fall at home
(Specify type of place)

While at work? no (e) Means of injury fall

23. Signature R. DeLanning (M. D. or other)
Address St. Genevieve Mo Date signed 12/16/44

38907