S. No. 2
M—9-4-41
. 5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 27 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40734

Registration District No. 42 | Primary Registration District No. 1400 | Registrar's No. 1283

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. No 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 0 yrs 9 1/2 mos (Specify whether years, months or days)

In this community: same

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Carroll

(c) City or town: Norborne

(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Maggie Witte

3. (b) If veteran, name war: —

3. (c) Social Security No. —

4. Sex: fem

5. Color or race: wh

6. (a) Single, widowed, divorced, married: w

6. (b) Name of husband or wife: Willie Witte

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

7. Birth date of deceased: April (Month) 15 (Day) 1892 (Year)

8. AGE: Years 52 Months 8 Days 2 If less than one day hr. min.

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

10. Usual occupation: housewife

11. Industry or business:

FATHER

12. Name: Charles Burre

13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Anna Kwifel

15. Birthplace: Germany (City, town, or county) (State or foreign country)

16. (a) Informant: hospital records

(b) Address:

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/20/44 (Month) (Day) (Year)

(c) Place: burial or cremation: St Hosp CEMETERY

18. (a) Signature of funeral director: John E. [illegible]

(b) Address: 605 4 PRYOR AVE

19. (a) 12-20-44 (Date received local registrar) (b) Helen J. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17 year 1944 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from March 1, 1944, to Dec 17, 1944; that I last saw her alive on Dec 17, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration: 4 mos

Cardiorenal disease

Due to: Cardiac hypertrophy

Due to:

Other conditions (Include pregnancy within 3 months of death): Mental deficiency with psychosis

Major findings: Of operations? No

Of autopsy: Cardiac hypertrophy; hydrothorax, cellulitis l. abdm

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)

While at work? (e) Means of injury

23. Signature: Dora Hochdorf M.D. (M. D. or other)

Address: State Hosp. No 2, St. Joseph Date signed 12/20/44

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(Licensed Embalmer's Statement on Reverse Side)

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 body was not embalmed, Registered Apprentice No. _____, working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St Joseph, 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.