

FILED JAN 12 1945
3/5

Registration District No. _____

Primary Registration District No. 6066

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Osceola (Rural)
(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 to Months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
(c) City or town Deepwater (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fritz Babler

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clara Babler 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased May 29 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Switzerland (City, town, or county) (State or foreign country) 5

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant F.A. Babler

(b) Address Osceola Missouri

17. (a) Burial (b) Date thereof 12-29-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Missouri

18. (a) Signature of funeral director Osceola Funeral Home
(b) Address Osceola Missouri

19. (a) 12-29-44 (b) A.B. Goodrich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 28
year 1944 hour 10 minute A M.

21. I hereby certify that I attended the deceased from Jan 1, 1943 to Dec 8, 1944
that I last saw him alive on Dec 8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death acute Insufficiency

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 C.S. Stratton (M. D. or other) MD
Address Lourey city, mo Date signed 12/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MAR 2 1945

12-44-1489
1-11-45

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 Paul D. Stone
Licensed Embalmer No. 3990
P. O. Address Orcutt 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.