

S. No. 2  
DM-2-43  
v. 5-17-39  
P. 1 X39697

Cutter  
6070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 7

FILED MAR 2 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3020

36  
66  
2  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Franklin  
(b) City or town Washington mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Dr. Frauts  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 weeks  
(Specify whether \_\_\_\_\_)  
In this community 40 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Franklin  
(c) City or town Washington mo. 36  
(If outside city or town limits, write "RURAL")  
(d) Street No. 826 Edith  
(If rural, give location) 6  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME KATHERINE MARIE SCHMIDT  
(b) If veteran, name war none  
(c) Social Security No. 498-14-5752

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 15  
year 1945 hour 5:10 minute 1 M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Emil F. Schmidt  
(c) Age of husband or wife if alive 64 years  
7. Birth date of deceased August 19 1884  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 13 to Jan 15, 1945  
that I last saw her alive on Jan 15 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
60 4 26 — hr. — min.

Immediate cause of death Carcinoma of left ovary  
Due to Not known  
Due to Not known

9. Birthplace Franklin Co Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife + Clerk

Other conditions None to my knowledge  
(Include pregnancy within 3 months of death)  
Major findings: Of operation all structures of pelvis are here involved  
Of autopsy no autopsy

MOTHER FATHER  
11. Industry or business Tayloring  
12. Name Henry A. Rofgt.  
13. Birthplace Franklin Co Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Wilhelmina Kuehl  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Emil F. Schmidt  
(b) Address Washington mo  
17. (a) Burial (b) Date thereof Jan 17 45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington mo.  
18. (a) Signature of funeral director Otto Co  
(b) Address Washington mo  
19. (a) 1-17-45 (b) Emil R. Brook  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature R. R. ... (M. D. or other) \_\_\_\_\_  
Address Washington Mo Date signed 1-18-45

1181

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

3-1-45

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.....

Licensed Embalmer No. 2464

P. O. Address

Washington 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.