DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

Dr. R. Williams
13370

State File No.

Registrar's No. 340

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: 535 S. Dollison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution, 2 Weeks
In this community 2 Weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 535 S. Dollison
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Susitte Aegerter

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

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

7. Birth date of deceased Nov. (Month) 20 (Day) 1868 (Year)

8. AGE: Years	Months	Days	If less than one day
76	5	1	hr. min.

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

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name Unk. Foster

13. Birthplace Unk. (City, town, or county) Switzerland (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Leo Webb

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Vernon ? Mo.

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

(b) Address Springfield, Mo.

19. (a) 4-23-45 (Date received local registrar) (b) E.W.E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21

year 1945 hour 6 minute 15a M.

21. I hereby certify that I attended the deceased from April 20, 1945, to April 20, 1945; that I last saw her alive on April 20, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Sudden Heart Attack	
following three day severe attack	
of Bronchial Asthma	
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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) No

(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 Robert Wellman, D (M. D. or other)

Address Springfield Mo Date signed 4-23-45

(Licensed Embalmer's Statement on Reverse Side)

APR 29 1948

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 Walter E Hamblin

Licensed Embalmer No. 3808

P. O. Address Springfield 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.