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5-17-39  
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21124

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FRI JUL 9 1945  
Registration District No. 576

Primary Registration District No. 6075

Registrar's No. 61

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Mo. State Hospital No. 4  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 yrs. 2 mos. 29 ds.  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade

(c) City or town Hermann  
(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 ANNA PLATTNER

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13  
year 1945 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from  
April 1, 1925 to June 13, 1945  
er June 13, 1945  
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race W.

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 About 1872  
(Month) (Day) (Year)

Immediate cause of death Atherosclerosis - Generalized 2 yrs  
Duration \_\_\_\_\_

8. AGE: Years About 73 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Constituted Imbecile  
(Include pregnancy within 3 months of death)

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

10. Usual occupation None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: 97  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER {

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

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? \_\_\_\_\_

16. (a) Informant Records State Hospital

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 6-15-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospt. Cen., Farmington, Mo.

18. (a) Signature of funeral director C. H. Coe

(b) Address Farmington, Missouri

19. (a) 6/22/45 (b) Ether Rudloff  
(Date received local registrar) (Registrar's signature)

23. Signatures \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address Farmington Date signed 6/20/45

1397

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4  
District File Number 745-866  
Date Filed 7-7-45

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.

*not embalmed*

Signed *C. Croze*  
Licensed Embalmer No. 4084  
P. O. Address *Farmington, Me.*

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.