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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 20 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 11

Primary Registration District No. 5041

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Barry

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

(c) City or town Rural Platteresh Twp
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Otto C. Scheele

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th
year 1945 hour 4 minute 45 M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: September 10 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 21 1945 to July 6 1945
that I last saw him live on July 6 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 9 Days 26 If less than one day
hr. _____ min. _____

Immediate cause of death: Uremia

Due to: Prostatic Hypertrophy

Due to: _____

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

10. Usual occupation Retired farmer

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

Major findings: Of operations 1370

Of autopsy _____

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

16. (a) Informant F. H. Scheele

(b) Address Cassville, Missouri

17. (a) Burial (b) Date thereof 7/9/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Antioch cemetery

18. (a) Signature of funeral director Culver Funeral Home

(b) Address Cassville, Missouri

19. (a) July 25-1945 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature E. E. McDaniel (M. D. or other) MD.

Address Cassville, Mo. Date signed 7/20/45

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

5
0
0

1077

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 845-891
Date Filed AUG 14 1945

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 Margaret Culver
Licensed Embalmer No. 4389
P. O. Address: Cassville

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.