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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 5 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27087

State File No.

Registration District No. 64 Primary Registration District No. 5243 Registrar's No. 57

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

1. PLACE OF DEATH:
(a) County CHARITON
(b) City or town RURAL (Rural)
(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 Chariton
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1 mile West Forest Green
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ELENORA KOTTMAN
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Alfred Kottman
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased NOV (Month) 4 (Day) 1896 (Year)

8. AGE: Years 48 Months 9 Days 22 If less than one day hr. min.

9. Birthplace Forest Green (City, town, or county) MO (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Her Home
FATHER
12. Name HENRY RAHWER
13. Birthplace Forest Green (City, town, or county) MO (State or foreign country)
MOTHER
14. Maiden name HELENA HAPPEMEISTER
15. Birthplace EMMA (City, town, or county) MO (State or foreign country)
16. (a) Informant Alfred Kottman
(b) Address Forest Green MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Salem Cemetery
18. (a) Signature of funeral director Walker Funeral Home
(b) Address Glasgow
19. (a) 8/26/45 (Date received local registrar) (b) [illegible] MO (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 5 hour 750 minute A M.
21. I hereby certify that I attended the deceased from 1-1-1942 to 8-26-1945, that I last saw her alive on 8-26-1945, and that death occurred on the date and hour stated above.
Immediate cause of death Acute Nephritis (Duration)
Due to
Due to
Other conditions [illegible] (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)
(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 W. B. Ritchie (M. D. or other) M.D.
Address Glasgow Mo. Date signed 8/26/45

1410 (Licensed Embalmer's Statement on Reverse Side)

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 J. Walker Audsley

Licensed Embalmer No. 3336

P. O. Address Glasgow 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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27087

Registration District No. 64 Primary Registration District No. 5243 Registrar's No.

1. PLACE OF DEATH:

(a) County Chariton

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

(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
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Elenora Kottman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov (Month) 4 (Day) 1896 (Year)

8. AGE: Years 48 Months 9 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug 26
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Really chronic with acute exacerbation & hypertension

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 130

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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)

(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 W B Kitchen (M. D. or other)

Address Glasgow Date signed

SUPPLEMENTARY

S-27087