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

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1166

FILED NOV 10 1945
Registration District No. 12

Primary Registration District No. 1000

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days)
In this community 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph /
(If outside city or town limits, write "RURAL")
(d) Street No. 2824 Seneca 7
(If rural, give location)
(e) Citizen of foreign country? no 0
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louise Rose Mohr
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex female / 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ralph Mohr
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased July 28 1904
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>41</u> | <u>3</u> | <u>1</u> | hr. _____ min. _____ |

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
12. Name Albert A. Gasaway
13. Birthplace unknown Illinois //
(City, town, or county) (State or foreign country)
14. Maiden name Louise Speckin
15. Birthplace Macon Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Mohr
(b) Address 2824 Seneca

17. (a) burial (b) Date thereof 10/30/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director W. B. Bickel & Bowman
(b) Address 319 South 10th

19. (a) Nov 2 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th
year 1945 hour 5 minute A M.

21. I hereby certify that I attended the deceased from July 45 to Oct 29 1945
that I last saw him alive on Dec 29 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Neurosyphilis
Duration ?

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature [Signature] (M. D. or other) Dr. D.
Address [Signature] Date signed 10/31/45

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

Dr. J. M. Williamson
Central Bldg.

APR 5 1946

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 Gerald J. Wade

Licensed Embalmer No. 4172

P. O. Address W. Joseph

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.