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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34465**

FILED NOV 3 1945

Primary Registration District No. **6048**

Registrar's No. **250**

1. PLACE OF DEATH:
 (a) County **St Charles**
 (b) City or town **Rural - Dardennette**
 (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 **MO** (b) County **St Charles**
 (c) City or town **Weddon Spring - Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) _____
 (e) Citizen of foreign country? **MO** (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Catherine M. Keiser**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **18** year **1945** hour _____ minute **5A** M.

4. Sex **Female** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Peter Rothe** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **MOY.** **9** **1861**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 4th** 19**45** to **Oct 18** 19**45**
 that I last saw her alive on **Oct 1** 19**45**
 and that death occurred on the date and hour stated above.

8. AGE: Years **84** Months **11** Days **9** If less than one day _____ hr. _____ min.

Immediate cause of death **Myocarditis** **10 yrs.**
 Due to **Arterio sclerosis** **10 yrs.**
 Due to _____

9. Birthplace **Weddon Spring MO** (City, town, or county) (State or foreign country)
10. Usual occupation **House Duties**

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations **ABP**
 Of autopsy _____

11. Industry or business _____
12. Name **Peter Rothe**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant **Clairde Keiser**
(b) Address **Weddon Spring MO**
17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** **10 21 45**
 (Month) (Day) (Year)
(c) Place: burial or cremation **Weddon Spring**

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 _____

18. (a) Signature of funeral director **J. E. Pittman**
(b) Address **Merriamville MO**
19. (a) Oct 29 45 **Boekethy**
 (Date received local registrar) (Registrar's signature)

23. Signatur **Nicholas J. Houch** (M. D. or D. O.)
Address **O. Fallon** **Date signed** **10/21/45**

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

MOTHER FATHER

682

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 11-5-45

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.

Signed.....

T. C. Pittman

Licensed Embalmer No.....

2711

P. O. Address.....

Westerville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 250

Registration District No. 306 Primary Registration District No. 6048

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

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town Rural Gardenme Imp
(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 years, months or days)

3. (a) PRINT FULL NAME Catherine M. Kerier

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color of race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Nov 9 1945
(Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ (If less than one day) min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Don't know Don't know

13. Birthplace Don't know Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Ann's Studt

15. Birthplace Don't know Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov 14 - 1945 (b) E. A. Reithly
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

34465