

S. No. 2  
M-542  
v. 5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38826

FILED DEC 7 1945  
Registration District No. 362

Primary Registration District No. 6232

Registrar's No. 27

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

1. PLACE OF DEATH:  
(a) County Warren Co., Bridgeport T.P.  
(b) City or town New Florence, Mo. Rural  
(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 35 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri. (b) County Warren Co.  
(c) City or town New Florence, Mo. Rural  
(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 Charlotte Graue,  
3. (b) If veteran, name war XX  
3. (c) Social Security No. XX

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 4th,  
year 1945 hour 10 minute 30 P. M.  
21. I hereby certify that I attended the deceased from Nov 4, 1945  
to Nov 4, 1945

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Wm H. Graue.  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 31st, 1861  
(Month) (Day) (Year)

That I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Coronary Thrombosis Duration 2 hrs.  
Due to Chronic Myocarditis ?  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
84 2 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Signature: [Signature]

9. Birthplace Warren Co., Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Anton Fasse,  
13. Birthplace Unknown Unknown.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Chas Blane  
(b) Address New Florence, Mo.  
17. (a) Burial (b) Date thereof Nov 7th, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Pleasant, near Hill Hill, Mo.  
18. (a) Signature of funeral director [Signature]  
(b) Address Americus, Mo.  
19. (a) Nov 6, 1945 (b) Mrs Hugo Luttmann  
(Date received local registrar) (Registrar's signature)

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?  
Hill, Mo.  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature James O. Helm (M. D. or other)  
Address New Florence Mo. Date signed [Signature]

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-6-45

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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.....

D. B. Baker, Registered Apprentice No.....

working under my personal supervision.

Signed D. B. Baker

Licensed Embalmer No. 3375

P. O. Address Americus, 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.