

FILED JAN 14 1946

State File No. _____

Registration District No. 363

Primary Registration District No. 6736

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Marthasville Rural
(c) Name of hospital or institution: Charrette
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Warren
(c) City or town Marthasville Rural
(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 Glaude Bowlus WHIPP

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louise 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased June 23 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Not known

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

14. Maiden name _____

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

16. (a) Informant Cornel C. Whipp

(b) Address Marthasville, Mo

17. (a) _____ (b) Date thereof Dec 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lenore Opage us

18. (a) Signature of funeral director Fred W. Libbitubery

(b) Address Marthasville Mo

19. (a) 12/20/45 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1945 hour _____ minute 8¹⁰ AM

21. I hereby certify that I attended the deceased from Sept 1
1945 to Dec 17 1945
that I last saw him alive on Dec 15 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery disease Duration 2 years

Due to arteriosclerosis 5 yrs

Due to _____

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

Major findings: Of operations 940 Of autopsy _____
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? _____

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

23. Signature Herbert H. Schardt (M. D. or other) _____
Address Marthasville, Mo Date signed 12-20-45

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

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 Fred. W. Lichtenberg
Licensed Embalmer No. 1721
P. O. Address Martha'sville 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.