

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5170**

FILED FEB 18 1946

Registration District No. _____ Primary Registration District No. **5430** Registrar's No. _____

1. PLACE OF DEATH

(a) County **Tennessee**

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

(c) Name of hospital or institution: **Tennessee**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community **36 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Franklin**

(c) City or town **Rural - Central Tennessee**
(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 **Katy Creason**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **5th** year **1946** hour **7** minute **a.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. **Small** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **2**

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

7. Birth date of deceased **Aug-14-1870**
(Month) (Day) (Year)

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to _____

Due to _____

Other conditions **94a**
(Include pregnancy within 3 months of death)

8. AGE: Years **75-** Months **4** Days **21** If less than one day _____ hr. _____ min.

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

10. Usual occupation **House work**

Major findings: Of operations _____

Of autopsy **no**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name **Rev. Schwingler**

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

14. Maiden name **Wanjaris - Rhinehardt**

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

16. (a) Informant **Verna Walker**

(b) Address **2208 Sullivan Ave - 2nd**

17. (a) **Burial** (b) Date thereof **12-8-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Val-Halla - Curving**

18. (a) Signature of funeral director **Sherrill Kitchell**

(b) Address **St. Clair Mo.**

19. (a) **1-6-1946** (b) **E. T. Worthington**
(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury **3**

23. Signature **E. F. Ottmann** **Coroner**
(Name and position)

Address **Union Mo** Date signed **1/5/1946**

96

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 2-14-46

59461 3 2 FEB

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 Shenwood Kitchell

Licensed Embalmer No. 3873

P. O. Address St. Clair, 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.