

No. 2  
-5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6706

FILED MAR 9 1946

State File No. \_\_\_\_\_

Registration District No. 23

Primary Registration District No. 5942

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rural Roca

(c) Name of hospital or institution: Roca Twp. 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: 11 years (Specify whether in hospital or institution)

In this community 11 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town Roca (If outside city or town limits, write "RURAL")

(d) Street No. Route 2

(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: Louise Mary Gebauer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5 year 1946 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from 2-1-1946 to 2-5-1946

that I last saw her alive on 2-5-1946 and that death occurred on the date and hour stated above.

4. Sex F. 1

5. Color or race Wh.

6. (a) Single, widowed, married, divorced, widower

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Oct. 9 1867 (Month) (Day) (Year)

Immediate cause of death: cerebral hemorrhage 5 da

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: senility (Include pregnancy within 3 months of death)

8. AGE: Years 78 Months 3 Days 26 If less than one day hr. min.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

9. Birthplace: St Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business \_\_\_\_\_

12. Name: Frederico Machel

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

14. Maiden name: Paulina Stahl

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

16. (a) Informant: Rose Gebauer

(b) Address: Roca

17. (a) Removal (b) Date thereof: Feb. 6 1946 (Month) (Day) (Year)

(c) Place: burial or cremation: St Louis Mo

18. (a) Signature of funeral director: \_\_\_\_\_

(b) Address: Roca Mo

19. (a) Feb. 5, 1946 (Date received local registrar)

(b) Mrs. Juanita Harvey (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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature: E. E. Feind, M.D. (M. D. or other)

Address: Roca Mo Date signed: 2-6-46

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..... *S. B. Muel* .....

Licensed Embalmer No. .... *3394* .....

P. O. Address..... *Rolla 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.**

Registration District No. 275-

Primary Registration District No. 5942

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Phelps  
 (b) City or town Rural, Ralla - Ralla Sup. &  
(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

In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Louise M. Gebauer

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

4. Sex F 5. Color or 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 Oct 9 (Month) (Day) (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) Mar. 16, 1946 (b) Mrs. Juanita Harvey  
(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 Feb year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_ 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)

Major findings: Of operations \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

6706