

V. S. No. 2
FORM-8-43
Rev. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U. S. DEPARTMENT OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 122

FILED APR 22 1946

Registration District No. 77 Primary Registration District No. 3008

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

1. PLACE OF DEATH:

(a) County Callaway Fulton

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

(c) Name of hospital or institution State Hospital No 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 yrs 9m 29d
(Specify whether years, months or days)

In this community 7 yrs 9m 29d

3. (a) PRINT FULL NAME Rosa Kistermann

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

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

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

7. Birth date of deceased Dr
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Dr

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

14. Maiden name Dr

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

16. (a) Informant Record

(b) Address _____

17. (a) Removal (b) Date thereof 3 18 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbians

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbians

19. (a) 3-18-1946 (b) Joie M. Moucheloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan 14

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

(d) Street No County In primary 2
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 16
year 1946 hour 3-15 minute 0 M.

21. I hereby certify that I attended the deceased from 3-15-46, 19____, to 3-16-46, 19____;
that I last saw h. w alive on 3-15-46, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to Arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 5 months of death) _____

Major findings:
Of operations _____

Of autopsy gze

Duration _____

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) Means of injury _____

23. Signature Gorgi H. Ruck (M. D. or other) MA
Address Fulton Mo Date signed 3-16-46

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-18-46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.