

FILED NOV 22 1946
Registration District No. 288

Primary Registration District No. 576/4300

Registrar's No. 50

1. PLACE OF DEATH: **Marion**
 (a) County **Palmyra**
 (b) City or town (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **413 West Church**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **11 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Marion 64**
 (c) City or town **Palmyra** (If outside city or town limits, write "RURAL")
 (d) Street No. **413 West Church Street** (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Stanley Foster Gottmen**

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

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

6. (b) Name of husband or wife **Helen M. Weller** 6. (c) Age of husband or wife if alive **40** years

7. Birth date of deceased **September 19 1907**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 1 18 hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Banard Gottman**

13. Birthplace **Marion County Missouri** (City, town, or county) (State or foreign country)

14. Maiden name **Nelle Foster**

15. Birthplace **Marion County Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Helen Gottman**
 (b) Address **Palmyra, Missouri**

17. (a) **Burial** (b) Date thereof **11/7/46**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Lewis Bean**
 (b) Address **Palmyra, Missouri**

19. (a) **11-17-46** (b) **Viola Beer**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **7**
 year **1946** hour **8** minute **45** p. M.

21. I hereby certify that I attended the deceased from **Nov 6**, 1946 to **Nov 7**, 1946
 that I last saw him alive on **Nov 7**, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death **Hodgkin's Disease** Duration **18 mo**

Due to _____

Due to _____

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

Major findings: Of operations _____
 Of autopsy **44 B**

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

23. Signature **J. P. Rames** (M. D. or other) **MO**
 Address **Palmyra Mo.** Date signed **11/11/46**

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed.....

Licensed Embalmer No. *7387*

P. O. Address..... *Palmyra, N.J.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 208

Primary Registration District No. 4320

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Palmira
(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
years, months or days)

3. (a) PRINT FULL NAME Stanley J. Gettner

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

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

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

7. Birth date of deceased. Sept 19 1920
(Month) (Day) (Year)

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

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

10. Usual occupation Stamer

11. Industry or business

12. Name

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

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) E. M. Luke, M.D. (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 Sept Day 19 Year 1920 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from 1920 to 1920; that I last saw him alive on Sept 19 1920 and that death occurred on the date and hour stated above. Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

357747