

V. S. No. 2
DOM-8-43
Rev. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39794**
Registrar's No. **396**

FILED DEC 19 1946

Registration District No. **47**

Primary Registration District No. **3068**

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

4
1
2

1. PLACE OF DEATH:
(a) County **CALLAWAY**
(b) City or town **FULFORD**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
STATE HOSPITAL I NO. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4y 11m 22dy**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **COLE**
(c) City or town **JEFFERSON CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **100 1/2 JACKSON**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ANNA BELLE GANSLOSER**
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 **WIDOW**
6. (b) Name of husband or wife **CHARLES GANSLOSER**
6. (c) Age of husband or wife if alive **?** years
7. Birth date of deceased **May 18 1869**
(Month) (Day) (Year)

8. AGE: Years **77** Months **6** Days **17** If less than one day hr. _____ min. _____

9. Birthplace **Missouri Terre Haute, Ind.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

MOTHER FATHER { 12. Name **CHARLES NORRIS**

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

14. Maiden name **OK**
15. Birthplace **OK**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hopital Reiner**
(b) Address _____

17. (a) **removal** (b) Date thereof **12-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Chamouis, Mo.**

18. (a) Signature of funeral director **Vernon M. Morter**
(b) Address **Linn Mo.**

19. (a) **12-7-1946** (b) **Joan Morsinkoff**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **7** year **1946** hour _____ minute **3 40 P. M.**
21. I hereby certify that I attended the deceased from **Dec 15** 1946 to **7 Dec** 1946;
that I last saw her alive on **7 Dec** 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL HEMORRHAGE** Duration **24 hours**

Due to _____
Due to _____

Other conditions **GENERAL ARTERIOSCLEROSIS**
(Specify conditions which suggest cause of death) PHYSICIAN _____

Major findings: Of operations **none**
Of autopsy **none granted**
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 **P. S. Tate** for **Dr. R. P. Pinner** (M.D. or other)
Address **State Hospital** Date signed **7 Dec 46**

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~~Date Filed~~ 12-17-45
~~District File Number~~
District Health Officer No. 9

RECEIVED

109 West 7

109 West 7

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 Vernon M. Morlon

Licensed Embalmer No. 4125

P. O. Address Leam, 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.