DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1947

Registration District No. 8

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4158

State File No. 633

Registrar's No. 3

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

1. PLACE OF DEATH:

(a) County: CRAWFORD Boone

(b) City or town: BOURBON RURAL #2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: NONE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: CRAWFORD 28

(c) City or town: BOURBON RURAL 2
(If outside city or town limits, write "RURAL")

(d) Street No.: RURAL 2
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: ANNIE CAROLYN GERBER

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: ✓

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: MARRIED

6. (b) Name of husband or wife: JOSEPH GERBER

6. (c) Age of husband or wife if alive: 63 years

7. Birth date of deceased: JUNE (Month) 11 (Day) 1883 (Year)

8. AGE: Years 63 Months 5 Days 22 If less than one day ____ hr. ____ min.

9. Birthplace: ST. GENIVIEVE (City, town, or county) MO (State or foreign country)

10. Usual occupation: HOUSEWIFE

11. Industry or business: HOME

FATHER
12. Name: PHILLIP MILLHILSER MUGHHEAUSLER
13. Birthplace: (City, town, or county) ____ (State or foreign country) ____

MOTHER
14. Maiden name: MARY RHODT
15. Birthplace: ST. GENIVIEVE (City, town, or county) MO (State or foreign country)

16. (a) Informant: JOSEPH GERBER
(b) Address: R2 BOURBON, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN (Month) 7 (Day) 1947 (Year)
(c) Place: burial or cremation: BURIAL CATHOLIC CEM

18. (a) Signature of funeral director: J. T. Williams
(b) Address: BOX 111 Sullivan Mo

19. (a) 1-29-47 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 4 year 47 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 1946 to 1-4 1947 that I last saw her alive on 1-3 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	7 days
Due to: Hypertension and	
Due to: arteriosclerosis	years
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: 93A	

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: 17

23. Signature: [illegible] (M. D. or other)
Address: Sullivan MO Date signed 1-6-47

(Licensed Embalmer's Statement on Reverse Side)

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 Lloyd W. Olson, Registered Apprentice No. —, working under my personal supervision.

Signed Lloyd W. Olson

Licensed Embalmer No. 4344

P. O. Address Box 111 Sullivan 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.