

3. No. 2
-12.45
5-17-39
X47070

FILED MAR 10 1947
Registration District No. 187

Primary Registration District No. 3040

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

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution:
Chillicothe Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Grundy 40

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

(d) Street No. 1/2 mile North-Farmersville
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Chris Herman Weismantel

3. (b) If veteran, name war Fr.-Gr. 1870

3. (c) Social Security No. No

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased August 24 1848
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>98</u>	<u>5</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace Erfurt Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name John Weismantel

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Augusta Fisher

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Walter Ramtaum

(b) Address Farmersville, Missouri

17. (a) Removal (b) Date thereof 2-17-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia, S. Dakota

18. (a) Signature of funeral director Norman Funeral Home

(b) Address Chillicothe, Missouri

19. (a) Feb - 15 / 47 (b) Frances B Neill
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1947 hour 3 minute 17 P. M.

21. I hereby certify that I attended the deceased from about Nov 1946 to Feb 15 1947

that I last saw him alive on Feb 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Chronic myocarditis</u>	<u>?</u>
Due to <u>Old age (98 yrs)</u>	
Due to _____	
Other conditions <u>Diabetes mellitus</u> (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____

Of autopsy 61

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 Joseph F. Gale (M. D. or other) MD

Address Chillicothe Mo Date signed Feb 15 47

DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
Cameron, Mo.

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 Elton F. Norman,

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.