

FILED APR 16 1947
Registration District No. **367**Primary Registration District No. **1244**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Washington**
 (b) City or town **Old Mines Mo.**
 (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 **15-3-8** years, months or days)

3. (a) PRINT FULL NAME **Rita Maxine Vilmar**

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 **Single**

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

7. Birth date of deceased **Jan. 8 1932**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
15 3 88 hr. min.9. Birthplace **Old Mines Mo.** (City, town, or county) (State or foreign country)10. Usual occupation **Student**

11. Industry or business _____

12. Name **Max J. Vilmar**13. Birthplace **Old Mines Mo.** (City, town, or county) (State or foreign country)14. Maiden name **Eileen Marie Coleman**15. Birthplace **Old Mines Mo.** (City, town, or county) (State or foreign country)16. (a) Informant **Max J. Vilmar**(b) Address **Cadet Mo. R.1**17. (a) **Burial** (b) Date thereof **4 18 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Old Mines Mo.**18. (a) Signature of funeral director **Boyer Funeral Home**(b) Address **Potosi Mo.**19. (a) **May 7 1947** (b) **Mrs. G. J. Creswell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Washington**
 (c) City or town **Old Mines Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **16**
year **1947** hour **1** minute **15** A.M.21. I hereby certify that I attended the deceased from **April 14** 19**47** to **April 16** 19**47**
that I last saw her alive on **April 15** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death

Staphylococcus
Septicemia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **g. u. A**

Of autopsy _____

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) (e) Means of injury _____

23. Signature **Mrs. G. J. Creswell** (M. D. or other) _____Address **Potosi Mo.** Date **4/16/47**

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. **4158**

P. O. Address. **Potosi Mo.**

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. 366

Primary Registration District No. 6244

1. PLACE OF DEATH:

(a) County Washington
(b) City or town old mine
(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 years, months or days)

3. (a) PRINT FULL NAME Rita M. Velina

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

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

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

7. Birth date of deceased Jan (Month) 15 (Day) 1947 (Year)

8. AGE: Years 15 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) May 1 47 (Date received local registrar) (b) Mrs G.F. Pennington (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 April 16
year 1947 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

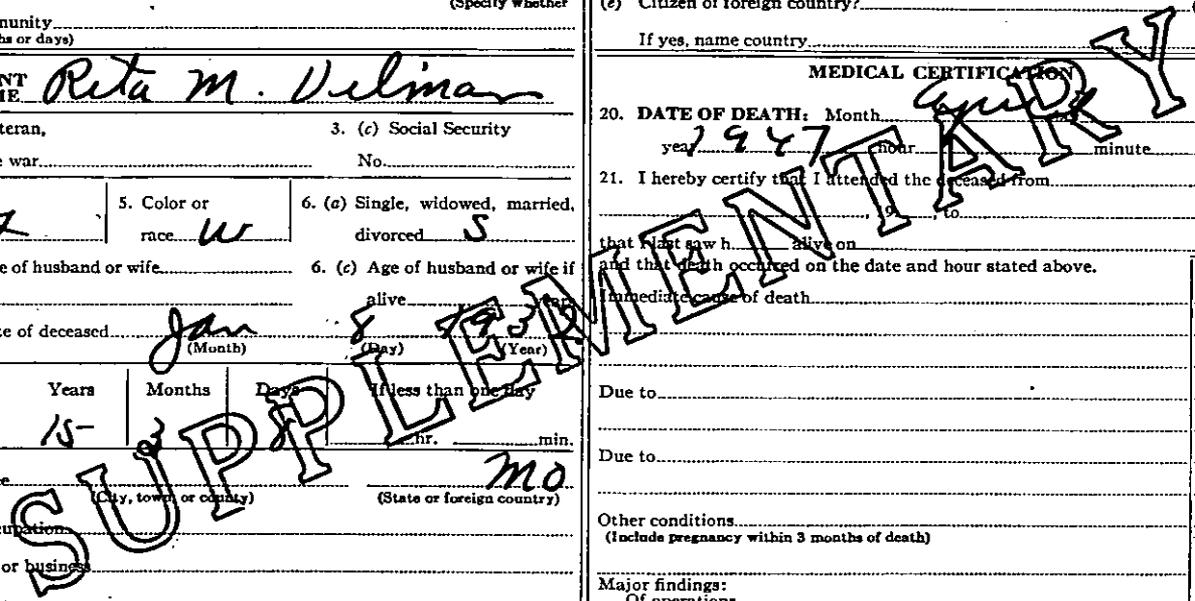
(c) Where did injury occur? _____ (City or town) (County) (State)

(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 _____ (M. D. or other)

Address _____ Date signed _____



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

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