

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 7 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30230**

Registration District No. _____

Primary Registration District No. **5016**

Registrar's No. **201**

1. PLACE OF DEATH:
 (a) County **Andrew**
 (b) City or town **Marion township**
(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 **44 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Andrew 2**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3 mi east of Coaley**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Esther Katherine Schotte**
 3. (b) veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Sept** day **23**
 year **1947** hour **10** minute **30 A.M.**
 21. I hereby certify that I attended the deceased from **November 1942** to **September 23, 1947**
 that I last saw her alive on **August 17, 1947**
 and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **w**
 6. (a) Single, widowed, married, divorced **m.**
 6. (c) Age of husband or wife if alive **41** years
 7. Birth date of deceased **April 2, 1903**
(Month) (Day) (Year)

Immediate cause of death **Myocardial degeneration**
 Due to **Mitral regurgitation**
 Due to **Rheumatic fever**
 Other conditions **1**
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	44	5	21	hr. _____ min. _____

9. Birthplace **Coaley Mo**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**

MOTHER FATHER

11. Industry or business _____
 12. Name **Fred Ladage 4**
 13. Birthplace **No Record Germany**
(City, town, or county) (State or foreign country)
 14. Maiden name **Katherine Woehr**
 15. Birthplace **No Record Germany 4**
(City, town, or county) (State or foreign country)

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Elwyn H. Schotte**
 (b) Address **Clarksdale, Mo**
 17. (a) **B** (b) Date thereof **Sept 25 47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Ion Evangelical**
 18. (a) Signature of funeral director **E. By Britt**
 (b) Address **Lavanna Mo**
 19. (a) **9-24-47** (b) **William Smith**
(Date received local registrar) (Registrar's signature)

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 **W. Maxwell** (M. D. or other) **MD**
 Address **Lavanna, Mo** Date signed **9/24/47**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.