

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37333**

FILED NOV 25 1947

Registration District No. **33**

Primary Registration District No. **3010**

Registrar's No. **357**

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau
(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 none (Specify whether)

In this community all life years, months or days (Specify whether)

3. (a) PRINT FULL NAME Martin Oberhide

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race W

6. (a) Single, ~~widowed~~, married, divorced 0

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Dec 15 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Cape Girardeau Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

MOTHER FATHER

11. Industry or business

12. Name William Oberhide

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

14. Maiden name Johanna Klum

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

16. (a) Informant Miss Alfy Hirsch

(b) Address Cape Girardeau

17. (a) Burial (b) Date thereof 11-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Larimer, Kuster

18. (a) Signature of funeral director J. J. Harold

(b) Address Cape Gir. Mo.

19. (a) 11-21-47 (b) C. C. Summers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

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

(d) Street No. Broadway (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 11

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1947 hour 3 minute 30 p. M.

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

Immediate cause of death Chromi Myocarditis

Due to Senility

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Ampt

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 3

23. Signature Dr. J. F. Sigmond Coroner
Address Jacobs, Mo. (M.D. or other) Date signed 11/19/47

RECEIVED

Sanitary Health Officer No. 4
District File Number 1147-1471
Date Filed 11-24-47

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 W. H. Estes

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau
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.