

FILED DEC 30 1947

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **416**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Elizabeth Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Days** (Specify whether
In this community **80 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Caroline Gottman**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Fritz Gottman** 6. (c) Age of husband or wife if alive **Dec. years**

7. Birth date of deceased **November 5 1858**
(Month) (Day) (Year)

8. AGE: Years **89** Months **1** Days **9** If less than one day hr. min.

9. Birthplace **Adams County, Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **John Bross**

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

14. Maiden name **Kate Zimmerman**

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

16. (a) Informant **Mrs Earl Gottman**

(b) Address **Palmyra, Mo.**

17. (a) **Burial** (b) Date thereof **12/16/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Wm Bros**

(b) Address **Palmyra, Mo.**

19. (a) **12-16-47** (b) **Dr. E. M. Lucke**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **14**
year **1947** hour **10** minute **20** p. M.

21. I hereby certify that I attended the deceased from **Dec 12** 19**47** to **Dec 14** 19**47**
that I last saw him alive on **Dec 14** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage & Apoplexy**
Due to **Apoplexy**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **8/3/47**

Of autopsy

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 **D**

23. Signature **Dr. E. M. Lucke** (M. D. or other)
Address **Hannibal Mo** Date signed

Duration **1 Day**
PHYSICIAN
Underline the cause to which death should be charged statistically.

Dec-16-47

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

Call Smith

unmarked

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..... *Scott Lewis*.....

Licensed Embalmer No. *2382*.....

P. O. Address..... *Palmyra-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.