

UNITED STATES DEPARTMENT OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17032**
Registrar's No. **8**

Registration District No. **234**

Primary Registration District No. **5816**

1. PLACE OF DEATH:

(a) County **Morgan Co**
(b) City or town **Rural**
(c) Name of hospital or institution **Richland Hosp**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **66 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Katie M. Monsees

3. (b) If veteran, name war

3. (c) Social Security No. **9**

4. Sex **F** / 5. Color or race **W**

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

6. (b) Name of husband or wife **M. P. Monsees**

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

7. Birth date of deceased **May 17 - 1876**
(Month) (Day) (Year)

8. AGE: Years **75** Months **11** Days **12** If less than one day hr. min.

9. Birthplace **Morgan Co MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **John Behrs**

13. Birthplace **Morgan Co MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Herman Helming**

15. Birthplace **Morgan Co MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Arthur Monsees**

(b) Address **Smithton MO**

17. (a) **Buried** (b) Date thereof **5-1-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **J. F. Monsees**

(b) Address **Smithton MO**

19. **May 17th 1948** (b) **John A. Ripberger**
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Morgan**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Richland Hosp**
(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 **29**
year **1948** hour **12** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **5 July**, 19**47**, to **29 April**, 19**48**, that I last saw her alive on **29 April**, 19**48**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration

Due to **Hypertension**

Due to **Atherosclerosis**

Other conditions **Cholelithiasis, Chronic**
(Include pregnancy within 3 months of death)

Major findings: Of operations **H**

Of autopsy **830**

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 **0**

23. Signature **P. F. Egan** (b) **MD**
Address **Smithton MO** Date **29 Apr 48**

RECEIVED
District Health Officer No. 7,
District File Number 4-48-564
Date Filed 3-24-48

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. 59

working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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.