

0. 2
8-43
7-39
37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25737

State File No. _____

Registration District No. 64

Primary Registration District No. 4109

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Keytesville
(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 all her life
years, months or days

3. (a) PRINT FULL NAME SOPHIA C. BARITZ

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 widowed

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

7. Birth date of deceased Feb. 17th 1857
(Month) (Day) (Year)

8. AGE: Years 91 Months 5 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. F. Jones

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

14. Maiden name Philippine Meyer

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

16. (a) Informant Dr. Leelyn Jones

(b) Address Keytesville

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Keytesville

18. (a) Signature of funeral director H. L. Jones

(b) Address Keytesville

19. (a) 8/16/48 (b) [Signature] (Registrar's signature) (Do not receive if local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton 21
(c) City or town Keytesville 10
(If outside city or town limits, write "RURAL") 00

(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 Aug day 14th
year 1948 hour 12 minute 50 A. M.

21. I hereby certify that I attended the deceased from April 6, 1939 to Aug 14, 1948
that I last saw her alive on Aug 13, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis 20 days
Cerebral sclerosis 5 yrs.

Due to generalized arteriosclerosis

Due to _____

Other conditions adenoma of thyroid - begun 60 yrs.
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____
Of autopsy 638

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 [Signature] (M. D. or other) MA

Address Keytesville Mo Date signed 8-16-48

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

MOTHER FATHER

Duration
Underline the cause to which death should be charged statistically.

PHYSICIAN

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 9-9-48

OCT 14 1948

NOV 16 1948

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 H. O. Gammitt

Licensed Embalmer No. 3046

P. O. Address Keytesville 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.