

No. 2
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17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
320
FILED OCT 7 1948
Registration District No. 219

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
6079 6080
Primary Registration District No. 6079 6080

31680

State File No. _____
Registrar's No. 60

1. PLACE OF DEATH:
(a) County ST. GENEVIEVE
(b) City or town RURAL SALINE T.S.
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community LIFE years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. GENEVIEVE
(c) City or town RURAL (If outside city or town limits, write "RURAL")
(d) Street No. COFFMAN (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country NO

3. (a) PRINT FULL NAME JOSEPHINE VOLT
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month SEPT day 30 year 1948 hour 6 minute P. M.
21. I hereby certify that I attended the deceased from Aug. 26 1948 to Sept 30 1948
that I last saw h. ER alive on Sept 30 1948 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ANDREW VOLT 6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased: NOV 4 1870
(Month) (Day) (Year)

Immediate cause of death: Coronary Thrombosis Duration 9/30/48
Due to arteriosclerosis ?
Due to _____

8. AGE: Years Months Days If less than one day
77 10 26 hr. _____ min.

Other conditions (Include pregnancy within 8 months of death) _____
Major findings: 940
Of operations _____
Of autopsy _____

9. Birthplace COFFMAN MO D
(City, town, or county) (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business _____

MOTHER FATHER
12. Name FRANK X GELL
13. Birthplace COFFMAN MO D
(City, town, or county) (State or foreign country)
14. Maiden name MARGARENA LEHR
15. Birthplace ST. GENEVIEVE CO MO D
(City, town, or county) (State or foreign country)

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

16. (a) Informant Andrew Volt
(b) Address St. Genevieve Mo. Ste. Route #1
17. (a) BURIAL (b) Date thereof OCT 4 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation COFFMAN MO

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? _____

18. (a) Signature of funeral director Spoc. Baxter
(b) Address St. Genevieve Mo.
19. (a) 10-4-48 (b) Theresa M. Taylor
(Date received local registrar) (Registar's signature) 3-50

While at work? _____ (Specify type of place) (c) Means of injury 0
23. Signature Robert J. Quinn M.D. (M. D. or other) _____
Address St. Genevieve Mo. Date signed 10/1/48

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

JAN 17 1950

~~DEC 17 1950~~

RECEIVED

Health Officer No. 4
Number 1048-125
10-6-48

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.....

working under my personal supervision.

Signed Geo. C. Butler

Licensed Embalmer No. 1985

P. O. Address St. Genevieve 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.