No. 2
—2-43
5-17-39
J X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 4 1948

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31846 State File No.

Registration District No. 324 Primary Registration District No. 4547 Registrar's No. 31

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Grant City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Worth 113
(c) City or town Grant City 16
(If outside city or town limits, write "RURAL")
(d) Street No. 5
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Frank Hulbert Mittelsteder
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex male 1 | 5. Color or race white | 6. (a) Single, widowed, married, divorced married 1

6. (b) Name of husband or wife Olive M.Mittelsteder | 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 7 (Month) 14 (Day) 1865 (Year)

8. AGE: Years 83 | Months 2 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Dayton (City, town, or county) Ohio (State or foreign country) 1
10. Usual occupation retired farmer
11. Industry or business

MOTHER
12. Name John Mittelsteder
13. Birthplace Germany (City, town, or county) (State or foreign country) 4

FATHER
14. Maiden name Mary Clipfield
15. Birthplace Ohio (City, town, or county) (State or foreign country) 1

16. (a) Informant Mrs.Olive M.Mittelsteder
(b) Address Grant City,Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-1948 (Month) (Day) (Year)
(c) Place: burial or cremation Grant City,Mo.
18. (a) Signature of funeral director Arch C. Dunfee
(b) Address Grant City,Mo.
19. (a) Sept 21-1948 (Date received local registrar) (b) Leta E. Dawson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
year 1948 hour 10 minute 10 P. M.
21. I hereby certify that I attended the deceased from Sept 18 19 48 to Sept 18 19 48
that I last saw him alive on Sept 17 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Failure	4 hrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Coronary Sclerosis	2 yrs

Major findings:
Of operations V
Of autopsy No

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) V
(b) Date of occurrence
(c) Where did injury occur? V (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? V (Specify type of place) (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed 9-19-48

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant city, 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.