

FILED FEB 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

55777

State File No.

| | | | | | | | |
|---|---|--|--|--|---|---|--|
| BIRTH NO. | | REG. DIST. NO. <u>214</u> | | PRIMARY REG. DIST. NO. <u>5778a</u> | | Registrar's No. <u>38</u> | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) | | | |
| a. COUNTY <u>Miller</u> | | b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Meta</u> | | a. STATE <u>MO</u> | | b. COUNTY <u>Miller</u> | |
| c. LENGTH OF STAY (in this place) <u>Life</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Meta MO</u> | | d. STREET ADDRESS (If rural, give location) <u>Jackson Township</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u> | | | | d. STREET ADDRESS (If rural, give location) | | | |
| 3. NAME OF DECEASED | | | 4. DATE OF DEATH | | | 5. SEX | |
| a. (First) | b. (Middle) | c. (Last) | (Month) | (Day) | (Year) | | |
| <u>Rose Gertrude Massman</u> | | | <u>2-8-1949</u> | | | <u>Female</u> | |
| 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u> | 8. DATE OF BIRTH <u>Dec 9 1921</u> | 9. AGE (In years last birthday) <u>27 yrs</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> | IF UNDER 1 HR. Hours <u></u> Min. <u></u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>MO U</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13a. FATHER'S NAME <u>William Massman</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Luckenoff</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mary Mannan</u> | | ADDRESS <u>Mother Meta MO</u> | |
| 18. CAUSE OF DEATH | | | | MEDICAL CERTIFICATION | | | |
| Enter only one cause per line for (a), (b), and (c) | | | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | ANTECEDENT CAUSES | | | |
| | | | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | |
| | | | | DUE TO (b) <u>Thyroidosis diabetes Mellitus</u> | | | |
| | | | | DUE TO (c) | | | |
| | | | | II. OTHER SIGNIFICANT CONDITIONS | | | |
| | | | | Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Disease</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan</u> , 1941, to <u>Feb 7</u> , 1949, that I last saw the deceased alive on <u>Feb 7</u> , 1949, and that death occurred at <u>5:20 pm.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Name or title) <u>Helen A. Jacobson, M.D.</u> | | | | 23b. ADDRESS <u>Meta, Mo</u> | | 23c. DATE SIGNED <u>2/8/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE <u>Feb 10-1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>St Lawrence cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>St Elizabeth Miller MO</u> | | |
| DATE REC'D BY LOCAL REG. <u>2-9-1949</u> | | REGISTRAR'S SIGNATURE <u>John B. Schweitzerman</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>H H Strop</u> | | ADDRESS <u>Meta MO</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9;
District File Number 2-17-49
Date Filed

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed H.H. Strop

Licensed Embalmer No. 2924

P. O. Address Meta Md

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.