

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40773

BIRTH NO. _____		REG. DIST. NO. <u>118</u>		PRIMARY REG. DIST. NO. <u>5441</u>		Registrar's No. <u>48</u>	
1. PLACE OF DEATH a. CITY Gasconade				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Gasconade			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Third Creek Twp 60yrs				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Third Creek Twp. 37			
d. FULL NAME OF HOSPITAL OR INSTITUTION /				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) Caroline b. (Middle) Witte c. (Last) Witte				4. DATE OF DEATH (Month) (Day) (Year) Dec. 20 1949			
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH 3-17-1863	
9. AGE (In years last birthday) 86		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY ***		11. BIRTHPLACE (State or foreign country) Bay, Mo. 7	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME *** Bierwirth		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Henry Witte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Ben H. Witte		ADDRESS Owensville, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rt. Hemiplegia - Due To ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intracranial Hemorrhage DUE TO (c) On Hypertensive Basis 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 ☐ NO ☒							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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 (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-17</u> , 19 <u>49</u> , to <u>12-20</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>49</u> , and that death occurred at <u>6:30 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Barbara Brenner, M.D.</u> (Degree or title)				23b. ADDRESS <u>Owensville, Mo.</u>		23c. DATE SIGNED <u>12-21-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE <u>12-23-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ev. Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Woollam, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 22, 1949</u>		REGISTRAR'S SIGNATURE <u>Dorothy Nickman</u>		363		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Winter</u> ADDRESS <u>OWENSVILLE</u>	

RECEIVED
DEC 27 1949
District Health Officer No. 9,
District VII, Number.....

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 me

Student Embalmer No.

working under my personal supervision.

Signed Melvin H. Winter

Signed
Student Embalmer

Licensed Embalmer No. 3858

P. O. Address Quincy, Ill.

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.