

FILED FEB 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3435

BIRTH NO. _____ REG. DIST. NO. 1317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 250

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) Baldwin, Mo. c. LENGTH OF STAY (in this place) 2 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Washington, Mo. d. STREET ADDRESS (If rural, give location) 808-1/2 5th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Pine Crest Nursing Home			

3. NAME OF DECEASED (Type or Print) Emma Marie Massmann	a. (First) Emma b. (Middle) Marie c. (Last) Massmann	4. DATE OF DEATH (Month) (Day) (Year) 2-1-1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug 21-1888	9. AGE (In years last birthday) 61 Months 5 Days 10	IF UNDER 1 YEAR Hours Min. 	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Union-Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ernest H. Massmann	13b. MOTHER'S MAIDEN NAME Bernadine Vidler Massmann	14. NAME OF HUSBAND OR WIFE (None)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Emma Massmann ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paget's Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Chronic cystitis rise to the above cause (a) stating the underlying cause last. DUE TO (c) Chronic myocarditis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		731X	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 731X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **Sept 26**, 1949, to **Feb 1st**, 1950, that I last saw the deceased alive on **Feb 1**, 1950, and that death occurred at **1 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) B. P. Loving, M.D.	23b. ADDRESS Baldwin, Mo.	23c. DATE SIGNED 2-1-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-4-50	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	24d. LOCATION (City, town, or county) (State) Washington, Mo.
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DATE REC'D BY LOCAL REG. 2-2-50	REGISTRAR'S SIGNATURE Robert P. Clonke, M.D.	FUNERAL DIRECTOR'S SIGNATURE Witt Inc. ADDRESS Washington, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed.....

A. P. Nieburg

Signed.....
Student Embalmer

Licensed Embalmer No. *2387*

P. O. Address *Washington, 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.