

FILED SEP 27 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5435 State File No. 26573  
Registrar's No. 27

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 119 PRIMARY REG. DIST. NO. 4193

1. PLACE OF DEATH a. COUNTY Gasconade 0370		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) Rural-Boeuf Twp		c. CITY (If outside corporate limits, write RURAL and give township) Hermann 0371	
d. FULL NAME OF HOSPITAL OR INSTITUTION 17 mi. South of Hermann		d. STREET ADDRESS (If rural, give location) 400 West Seventh St., 0	

3. NAME OF DECEASED (Type or Print) a. (First) CAROLINE b. (Middle) c. (Last) GILLIG			4. DATE OF DEATH (Month) (Day) (Year) Aug. 16, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 22, 1869	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Hours Days
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) Germany 4		12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME Frederick Jungblut		13b. MOTHER'S MAIDEN NAME Whilemina Schlueter		14. NAME OF HUSBAND OR WIFE George Gillig	
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 ADDRESS Hy Jungblut, R #1 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left ventricular failure		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic changes in coronary circulation			15 yrs.
	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 4200		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 Dec. 12, 1949, to Aug. 17, 1951, that I last saw the deceased alive on Aug. 13, 1951, and that death occurred at 9:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title) D.O.		23b. ADDRESS Hermann, Mo		23c. DATE SIGNED 8/18/51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-20-51		24c. NAME OF CEMETERY OR CREMATORY Bay St. Paul Cemetery		24d. LOCATION (City, town, or county) (State) Hermann, Mo	
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DATE REC'D BY LOCAL REG. 8/20/51		REGISTER'S SIGNATURE <i>[Signature]</i>		EMERALD DIRECTOR'S SIGNATURE August Plemer		ADDRESS Hermann, Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

SEP 4 - 1951

RECEIVED

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 \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed..... *August Blumer*

Licensed Embalmer No. 3160

P. O. Address Hermann, 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.