

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

2140

State File No.

BIRTH NO. --- REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 3048 Registrar's No. 25

1742

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

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, write RURAL and give township) Maryville Mo 4 months		c. LENGTH OF STAY (In this place) 4 months	
c. CITY (If outside corporate limits, write RURAL and give township) Grant City Mo 1130		d. STREET ADDRESS (If rural, give location) 5 mile South West	
d. FULL NAME OF HOSPITAL OR INSTITUTION Price Apartments			
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) William c. (Last) Breit		4. DATE OF DEATH (Month) (Day) (Year) January 19 - 52	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 30 - 1871
9. AGE (in years last birthday) 80 IF UNDER 1 YEAR (Months) 5 IF UNDER 1 HR. (Hours) 19 (Min.) 1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	
10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTH PLACE (State or foreign country) Barnard Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Frederick Breit	
13b. MOTHER'S MAIDEN NAME Deliah Fix		14. NAME OF HUSBAND OR WIFE Maude Breit	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Maude Breit		ADDRESS Grant City 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) Tobacco Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Influenza 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 checked="" type="checkbox"/>		480X	
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 Jan 2 , 1952, to Jan 19 , 1952, that I last saw the deceased alive on Jan 19 , 1952, and that death occurred at 10:00 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. J. Garten M.D.		23b. ADDRESS Maryville Mo	
23c. DATE SIGNED 1-24-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 21 - 52	
24c. NAME OF CEMETERY OR CREMATORY Oak Lawn		24d. LOCATION (City, town, or county) (State) Ravenwood Mo	
DATE REC'D BY LOCAL REG. 2-2-52		REGISTRAR'S SIGNATURE Bess Holt	
25. FEDERAL DIRECTOR'S SIGNATURE John Andrews		ADDRESS Grant City Mo	

OCT 15 1939

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 _____

John Andrews

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *John Andrews* _____

Licensed Embalmer No. *4211* _____

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.