

FILED MAY 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11439**

BIRTH NO. _____		REG. DIST. NO. <u>99</u>		PRIMARY REG. DIST. NO. <u>5379</u>		Registrar's No. <u>12</u>		
1. PLACE OF DEATH a. COUNTY <u>Dekalb</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dekalb</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Sherman Twp.</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>Clarksdale Rural Sherman Twp</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RFD # 1 Clarksdale</u>				d. STREET ADDRESS (If rural, give location) <u>Rural Route # 1</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Michael</u>			b. (Middle) _____		c. (Last) <u>Gottswiller</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 7, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug. 18, 1867</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Buchanan Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Michael Gottswiller</u>			13b. MOTHER'S MAIDEN NAME <u>Rosine Berkley</u>		14. NAME OF HUSBAND OR WIFE <u>Belle Louise</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 ADDRESS <u>Geo. Gottswiller Clarksdale, Mo.</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocardial insufficiency</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>		
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) <u>Stewartsville, Mo.</u>				
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 <u>Jan</u> , 19 <u>53</u> , to <u>March 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>55</u> , and that death occurred at <u>10:12</u> a. m., from the causes and on the date stated above.								
23a. SIGNATURE <u>E. J. Dwyer</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>Stewartsville, Mo.</u>			23c. DATE SIGNED <u>3-9-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-10-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Platteville Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Platteville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3-10-55</u>		REGISTRAR'S SIGNATURE <u>Harold W. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman ...</u>		ADDRESS <u>St. Joseph Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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.

Student
Student Embalmer

Signed Robert H. Gable _____

Licensed Embalmer No. 3308 _____

P. O. Address St. Joseph, 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.