

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012027

STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 381

Primary Registration District No. 6179

Registrar's No. 28

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Jackson Twp.</u> 10-58
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Margaret Rachel</u> Middle <u>Gewitz</u> Last <u>Gewitz</u>			4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-1867</u>		9. AGE (In years last birthday) <u>92</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Athens Co. Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
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13a. FATHER'S NAME <u>Wm. T. Robbins</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Boyles</u>		14. NAME OF HUSBAND OR WIFE <u>Charles E. Gewitz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Madie Streeter - 1200 L-120</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile changes -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arthritis -</u>			
DUE TO (c) <u>Paraplegia R. side -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>725X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u>7:00</u> Month <u>4</u> Day <u>5</u> Year <u>1959</u> a.m. p.m.					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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21. I attended the deceased from 1948 to 4-59 and last saw her him alive on 4-3-59
Death occurred at 7:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>E. W. Simpson D.O.</u>		22b. ADDRESS <u>Milan - MO.</u>		22c. DATE SIGNED <u>4-6-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>4-7-59</u>		<u>Astland Cemetery</u>		<u>St. Joseph Mo</u>	

24. FUNERAL DIRECTOR <u>Schoenes</u> <u>Dorset Schoene</u>		ADDRESS <u>Milan - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-8-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Dwight Schoene*

Licensed Embalmer No. *2467*

P. O. Address *Nuland, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.