MAR 25 1930

37

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

4604

1. PLACE OF DEATH
County Gasconade Registration District No. 303
Township ~~Bothe~~ Roark Primary Registration District No. 5420
City ..... (No. ....., ... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME LOUIS FREDERICH LESSINGER
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE OF~~ MARY LESSINGER

6. DATE OF BIRTH (MONTH, DAY AND YEAR) AUG. 22 - 1870

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
59	5	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work FARMER
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) CALIFORNIA
(STATE OR COUNTRY) MO.

PARENTS
10. NAME OF FATHER FRED LESSINGER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) SWITZERLAND
12. MAIDEN NAME OF MOTHER NEE SCHNEIDER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) SWITZERLAND

14. INFORMANT Mary Lessinger
(Address) HERMAN MO. RH1

15. FILED 2-13, 1930 Anna K Rickhoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 12 1930

17. I HEREBY CERTIFY, That I attended deceased from Febr 6, 1930, to Febr. 12, 1930 that I last saw him alive on Febr 12, 1930, and that death occurred, on the date stated above, at 4:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108 101a (duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (SECONDARY) none
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at place of death
0 DID AN OPERATION PRECEDE DEATH? no. DATE OF none
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) John Engelbrecht, M. D
, 19 (Address) Stony hill, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: PRUSPATERIAN SWISS
DATE OF BURIAL: FE 14 1930

20. UNDERTAKER: HERMAN BLUMER
ADDRESS: BERGER MO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PERMANENT WITH UNFADING INK—THIS IS A PERMANENT RECORD