

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

Do not use this space.

12181
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File No. _____
Registered No. 25
St. _____ Ward _____

1. PLACE OF DEATH

36 County Franklin
Township St. John
City _____ (No. _____)

Registration District No. 197
Primary Registration District No. 3414

2. FULL NAME Arline Sophia Lause

(a) Residence. No. Krakow, Mo. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 3 mos. 18 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 18th, 1931

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>0</u>	<u>3</u>	<u>18</u>	

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

9. BIRTHPLACE (CITY OR TOWN) St. John's Township /
(STATE OR COUNTRY) Missouri

PARENTS	10. NAME OF FATHER <u>Edmund Lause</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Franklin Co.</u> (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>Agatha Marquart</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Franklin Co.</u> (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT Edmund Lause
(Address) Krakow, Mo.

15. Apr 7 1932 O. L. Munn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 6 1932

17. I HEREBY CERTIFY, That I attended deceased from April 2 1932 to April 6 1932
that I last saw him alive on April 5 1932 and that death occurred, on the date stated above, at 2:45-p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Bronchitis
106A / 106B
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Place of death
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? No.
(Signed) J. D. Manfrique, D.

. 19 (Address) Washington 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 Catholic Cemetery, Krakow, Mo. DATE OF BURIAL 4/8/ 19 32

20. UNDERTAKER Otto & Co., Washington, Mo. ADDRESS _____

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.

MAY 24 1932

