

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

Do not use this space.

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1. PLACE OF DEATH, Pettis
County..... Registration District No. 668
Township..... Primary Registration District No. 3032
City..... Sedalia (No. Bothwell Hosp.) St. Ward) 39

2. FULL NAME Mrs. John Lockmann
(s) 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.

8754

File No.
Registered No.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 John Lockmann

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-14-1877

7. AGE 54 YEARS 5 MONTHS 19 DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) Mt Hulda (STATE OR COUNTRY) Missouri

13. NAME Dick Lutjen

14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY)

15. MAIDEN NAME Maggie Meyer

16. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY)

17. INFORMANT Mrs Minnie Eding (ADDRESS) Cole Camp Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Hulda DATE 2-5-1933 19.

19. UNDERTAKER E L Eickhoff (ADDRESS) Cole Camp MO

20. FILED 2-4-33 19 J. L. Love Registrar.

2. MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 3 19 33

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1933, to Feb 3, 1933
I last saw him alive on Feb. 3, 1933. Death is said to have occurred on the date stated above, at 3:30 p.m.

The principal cause of death and related causes of importance were as follows:

Cancer of gallbladder and liver Date of onset 1-23-33

Other contributory causes of importance:

Name of operation Exploratory Laboratory Date of 1-23-33
What test confirmed diagnosis? Yes Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury....., 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify M. P. Shy, M. D.
(Signed) Sedalia Mo (Address) M. D.

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES

PHYSICS DEPARTMENT
5712 S. DICKINSON DRIVE
CHICAGO, ILLINOIS 60637

Dear _____:

I am pleased to inform you that your application for admission to the Ph.D. program in Physics has been accepted. You will be joining the Department in the fall of 19____.

Your research interests in _____ are in line with the current work of the Department. We are particularly interested in _____ and _____.

You will be working with _____, who is currently an Assistant Professor in the Department. He is an expert in _____ and _____.

The Department has a strong reputation for its research in _____ and _____. We have a number of excellent graduate students and postdoctoral fellows who are working in these areas.

We are confident that you will find the Department a stimulating and productive environment in which to pursue your research. We look forward to meeting you in the fall.

Sincerely,

Chairman, Department of Physics

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pettis Registration District No. 668 File No. _____
 Township _____ Primary Registration District No. 30-32 Registered No. 39
 City Scalia (No. _____, Northwell Hosp. St. _____ Ward _____)

2. FULL NAME Mrs. John Lockman

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 14 - 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 5 19

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19__

19. UNDERTAKER (ADDRESS)

20. FILED 2-4 1933 J. L. Love Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 3, 1933

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Case of gall bladder (Date of onset _____)

Other contributory causes of importance:
primary seat gall bladder

Name of operation Exploratory Lapotomy Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____.
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) _____, M. D.
 (Address) _____

SUPPLEMENTARY

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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