

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

REC'D MAR 17 1939

6488

Do not use this space.

1. PLACE OF DEATH

(a) County Lasconade Registration District No. 302
 (b) Township CD 17 Primary Registration District No. 6231
 (c) City CD 17 (d) Street No. 2 St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 250 Hermann F. Lozeschin
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Lozeschin
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS 67 MONTHS 9 DAYS 15 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 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) Hopkinton Mo

13. NAME Hare Lozeschin

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

15. MAIDEN NAME Henriette Schlotter

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

17. INFORMANT (ADDRESS) Mrs. Louis Francis Beller Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Ev. Cem. DATE 2-15-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lasconade Bland Mo

20. FILED 2-13-39 CA Binger Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1934 to Feb 15, 1939
 That saw him alive on 2-8-39, 1939 Death is said

to have occurred on the date stated above, at 8 m.
 The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis Date of onset

Other contributory causes of importance: 27

Name of operation 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) Ch. Binger, M. D.

(Address) Bland Mo

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,

Victor Buescher

, or by

Registered Apprentice No., working under my personal supervision.

Signed

Victor Buescher

Licensed Embalmer No.

3701

P. O. Address

J.C. 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

6488

Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade Registration District No. 302
(b) Township Clay Primary Registration District No. 6231
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Hermann F Czeschke St. _____ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-15-1939

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1873

I last saw h. _____ alive on _____, 19____. Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 9 15

to have occurred on the date stated above, at _____ m.

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

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

11. Total time (years) spent in this occupation _____

Date of onset _____

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

Other contributory causes of importance: _____

13. NAME

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

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

15. MAIDEN NAME

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

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.

17. INFORMANT (ADDRESS) _____

Manner of injury _____

Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

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

If so, specify _____

(Signed) C. J. Bunge, M. D.

(Address) Blount

20. FILED 2-15-39 19____

Local Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

