

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

44939  
 Do not use this space.

1. PLACE OF DEATH 2

(a) County WARREN Registration District No. 881  
 (b) Township Warrens Primary Registration District No. 6173  
 (c) City TRELEAAR (d) Street No. \_\_\_\_\_ St.  
 (e) Length of residence in city or town where death occurred 37 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MARTIN LEFHOLS

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**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 CHRISTINA LEFHOLS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-29-1969

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>70</u>	<u>4</u>	<u>3</u>	

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. RETIRED  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation. 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) SMITH CREEK MO.

FATHER

13. NAME Dietrich Lefholz  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Mina Rauch  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) H. O. Scholte  
Union, Warren Co. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Golden Mo. DATE Jan 3, 1940

19. FUNERAL DIRECTOR (ADDRESS) H. O. Scholte  
New Haven Mo.

20. FILED Jan 2, 1940 Warrens Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 31 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 30 1939 to Dec 31 1939  
 I last saw him alive on Dec 31 1939 Death is said to have occurred on the date stated above, at 5:30 P.M.  
 The principal cause of death and related causes of importance were as follows:

<u>Bronchopneumonia</u>	Date of onset
<u>(Primary)</u>	<u>Dec 25</u>
<u>Chronic Myocarditis</u>	<u>1930</u>
<u>Arterio Sclerosis</u>	<u>1935</u>

Other contributory causes of importance: \_\_\_\_\_

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? No  
 If so, specify \_\_\_\_\_  
 (Signed) E. O. Hartman M. D.  
Warrenton Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM 7-20-37 I X12004

STATEMENT BY LICENSED EMBALMER

I, Carl C. Furtig, Licensed Embalmer No. 3385

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Carl C. Furtig

Licensed Embalmer No. \_\_\_\_\_

**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.)**