

Registration District No. 296Primary Registration District No. 4180

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County Franklin  
 (b) City or town Union  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: S.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME John Frank Terschluse 624

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Thresa Augusta 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased April 22 1871  
(Month) (Day) (Year)8. AGE: Years 69 Months I Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Clover Bottom, Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Labor

11. Industry or business \_\_\_\_\_

12. Name Henry W. Terschluse13. Birthplace Germany  
(City, town, or county) (State or foreign country)14. Maiden name Adelheid Bolland15. Birthplace Germany  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature: Mrs. Thresa Terschluse(b) Address Union, Missouri.17. (a) Burial (b) Date thereof June 1, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation I. C. C. Church Cemetery18. (a) Signature of funeral director Wm. H. Howe(b) Address Union, Missouri.19. (a) 5-21-40 (b) Louis T. Howe M.D.  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri. (b) County Franklin.  
 (c) City or town Union, Missouri.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28  
year 1940 hour 7 minute 45 A. M.21. I hereby certify that I attended the deceased from 12/1/39, 1940 to 5/28, 1940  
that I last saw him alive on 5/26/, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Recurrent cerebral hemorrhage in right area & extending over motor cortex  
Due to \_\_\_\_\_ Duration 5/27/40  
To 5/28/40Due to first cerebral hemorrhage occurred 12/1/39

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Michael Heffrich (M. D. or other) \_\_\_\_\_  
Address Union, Mo. Date signed 5/21/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*W. H. Horn*

Licensed Embalmer No. *3175*

P. O. Address *Union, 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.**