

No. 2
1-10-39
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X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28461**

SEP 19 1940
AUG 13 1940
Registration District No. **220**

Primary Registration District No. **5417**

Registrar's No. _____

1. PLACE OF DEATH: **FRANKLIN.**

(a) County **FRANKLIN.**

(b) City or town **RURAL LYON**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **9**
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME **CAROLINA KAASE 2ND**

8. (b) If veteran, name war _____ **8. (c) Social Security** No. _____

4. Sex **Female** **5. Color or race** **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased **DEC 8 1862**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	8	18	hr. _____ min. _____

9. Birthplace **GERMANY** **6**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **WILLIAM SCHLAK**

13. Birthplace **GERMANY** **6**
(City, town, or county) (State or foreign country)

14. Maiden name **CLARA RICHTER**

15. Birthplace **GERMANY** **6**
(City, town, or county) (State or foreign country)

16. (a) Informant **HOUTS KAASE**
(b) Address **BEAUFORT MO**

17. (a) BURIAL (b) Date thereof **AUG 28 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **JEFFRIESBURG MO**

18. (a) Signature of funeral director **G. L. Jensen**
(b) Address **Beaufort Mo**

19. (a) 8-27-40 (b) **J. Matthews**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **FRANKLIN**

(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")

(d) Street No **RESIDENCE RURAL ROUTE**
(If rural, give location) **BEAUFORT MO**

(e) If foreign born, how long in U. S. **Since childhood** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **26**
year **1940** hour **14** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **June 29**
1940 to **Aug 26** **1940**
that I last saw her alive on **Aug 24** **1940**
and that death occurred on the day and hour stated above.

Immediate cause of death **Chronic**
Cardio-renal
disease **7**

Due to _____

Due to _____ **95%**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? **271**

While at work _____ (Specify type of place)
(a) Means of injury _____

23. Signature **J. Matthews** (M. D. or other) **1**
Beaufort Mo Date signed **8-27-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

E. H. Tennant

working under my personal supervision.

Registered Apprentice No.

Signed

E. H. Tennant

Licensed Embalmer No.

3076

P. O. Address

Beaufort 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.