No. 2 ;
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17-39
23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38192

Registration District No. DEC 18 1941 238

Primary Registration District No. 4145

Registrar's No.

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Lockwood, Mo Twp

(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 (Specify whether years, months or days)

In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(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.

3. (a) PRINT FULL NAME Mary Katherine Haunschild

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 14-1872 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
69	10	24	hr. min.

9. Birthplace Johnnesburg, Illinois (City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business

FATHER

12. Name August Helmkamp

13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Anna Vette

15. Birthplace Hanover Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs W. L. James

(b) Address Wewoka Oklahoma

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10-1941 (Month) (Day) (Year)

(c) Place: burial or cremation Lunterah Cemetery

18. (a) Signature of funeral director R. L. Haunschild

(b) Address Lockwood, Mo

19. (a) Dec 9-41 (Date received local registrar) (b) J. A. Wren (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8 year 1941 hour 1 minute 25 P.M.

21. I hereby certify that I attended the deceased from Dec 1940, 19, to Dec 8, 1941; that I last saw her alive on Dec 8-1941, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to Myocarditis	
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?

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

23. Signature James A. Wren (M. D. or other)

Address Lockwood Mo Date signed 12-9-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1241-1891
DEC 16 1949
Date Filed

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 W.C. ....., Registered Apprentice No. .....
working under my personal supervision.

Signed R. LeHamsfeld
Licensed Embalmer No. 1234
P. O. Address Lockwood M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
—6-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38192

Registration District No. 238 Primary Registration District No. 4145 Registrar's No.

1. PLACE OF DEATH:
(a) County: Dade
(b) City or town: Lockwood (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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Dade
(c) City or town: Lockwood Mo (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Mary K. Hausschild
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F.
5. Color or race: W.
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Jan 14, 1873 (Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
MOTHER 15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 12-10-41 (Date received local registrar) (b) J. E. Wren (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY