

Registration District No. 335

Primary Registration District No. 4492

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Oran
(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 _____)
In this community _____
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Oran
(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.? several 0 years.

3. (a) PRINT FULL NAME Adolph Lindoerfer
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced widowed
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar 28 1876
(Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 24
If less than one day _____ hr. _____ min.

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

10. Usual occupation Painter

11. Industry or business _____

12. Name unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant J. A. Clise
(b) Address Oran Mo
17. (a) Burial (b) Date thereof 1-22-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director J. S. Heiser
(b) Address Oran Mo
19. (a) 31 3/43 (b) J. S. Heiser
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1943 hour 6 minute - P. M.
21. I hereby certify that I attended the deceased from 12/11 1942 to 1/21 1943
that I last saw him alive on 1/21 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis 1942
Duration _____

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? _____

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

23. Signature J. A. Clise (M. D. or other)
Address Oran Mo Date signed 1/22/43

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

20
4
0

140
4
0

P

752

RECEIVED

District Health Office No. 2

District File Number 242-177

Date Filed 2-5-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.