V. S. No. 2
0M—9-4-41
Rev. 5-17-39
EXP I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

9164

State File No.

FILED MAR 20 1943

Registration District No. 1349

Primary Registration District No. 1002

Registrar's No. 1213

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 709 Washington! (If not in hospital or institution, write street number or location)

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

In this community 1 year. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 48

(c) City or town Kansas 3 (If outside city or town limits, write "RURAL") 8

(d) Street No. 709 Washington (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Carl Lauer

3. (b) If veteran, name war Do not know

3. (c) Social Security No. Do not know

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Unk 1875 (Month) (Day) (Year)

8. AGE: Years 68 | Months — | Days — | If less than one day — hr. min.

9. Birthplace Do not know (City, town, or county) 9 (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Do not know
13. Birthplace (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Do not know
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Jackson Corners office

(b) Address K C Mo.

17. (a) School (Burial, cremation, or removal) (b) Date thereof March 11-43 (Month) (Day) (Year)

(c) Place: burial or cremation Kirkville College of Osteopathy & Surgery Kirkville Mo

18. (a) Signature of funeral director Parsantino Bros

(b) Address K C Mo

19. (a) 3/10/43 (Date received local registrar) (b) M. M. Gower (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1943 hour 10 minute 25 P. M.

21. I hereby certify that I attended the deceased from Arrow, 19 to , 19 that I last saw h alive on , 19 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to 93.5

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Inspection & Anatomy

Duration

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 [illegible] (M. D. or other) 3/9/43

Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. C. 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, fact should be so stated above.