

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

X32873

LED MAY 20 1943

Registration District No. 774

Primary Registration District No. 3035

Registrar's No. 29

1. PLACE OF DEATH

(a) County Lafayette  
(b) City or town Lexington  
(c) Name of hospital or institution 26th + Grandblum bl.  
(d) Length of stay: In hospital or institution  
In this community, most of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Lexington  
(d) Street No. 26th Grandblum  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME EDWARD LIERMAN

3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Emma G. Ashford 6. (c) Age of husband or wife if alive, years  
7. Birth date of deceased March 11 1868 (Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 13 If less than one day hr. min.

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

10. Usual occupation Coal Miner

11. Industry or business

12. Name Daniel Lieman

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

14. Maiden name Mary Lieman (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Charlene Keller (b) Address Lexington Mo

17. (a) Burial (b) Date thereof April 26 1943 (c) Place: burial or cremation Lexington (Month) (Day) (Year)

18. (a) Signature of funeral director Winkler (b) Address Lexington Mo

19. (a) May 5 43 (b) Mrs. G. Schwab (c) Registrar's signature (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24 year 1943 hour 3 minute 00 P. M.  
21. I hereby certify that I attended the deceased from July 1942 to Apr. 24 1943 that I last saw him alive on 4/24 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration

Due to...  
Due to...  
Other conditions acute nephritis (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) no  
(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. D. Cape (M. D. or other) Address Lexington Mo Date signed Apr 25

copy

District No. 8,

District File Number

Date Filed 5-13-43

**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 Geo A McKean

Licensed Embalmer No. 2983

P. O. Address Wilmington, Md

**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.**

Registration District No. 174

Primary Registration District No. 3035

1. PLACE OF DEATH

(a) County Lafayette

(b) City or town Del Norte  
(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 Life (Specify whether)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME Edward Lierman

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 W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar. 11 1911  
(Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

{ 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

{ 14. Maiden name \_\_\_\_\_

{ 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. Day 24  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration \_\_\_\_\_

Due to acute nephritis

Due to chronic nephritis and damaged heart with resulting poor blood supply.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_ 1318

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

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)

(b) 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 \_\_\_\_\_

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

SUPPLEMENTAL

5-18234