

Registration District No. 173

Primary Registration District No. 5643

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Freedom Township Rural
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 78 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MELINDA CLARA LOHMAN

3. (b) If veteran, name war ✓ 3. (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 William Lohman 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Sept 10 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Lafayette Co Mo (City, town, or county) (State or foreign country) ✓ 0

10. Usual occupation Housework

11. Industry or business ✓

12. Name Fritz Sedeke

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

14. Maiden name Charlotte - Unknown

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

16. (a) Informant Gustav Lohman

(b) Address Concordia Mo

17. (a) Burial (b) Date thereof St. Mary's Lutheran (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director H. J. Dussing

(b) Address Concordia Mo

19. (a) April 20 - 1943 (b) Mrs. Walter Walpenhorst (Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month April day 18th year 1943 hour 3 minute 10-A M.

21. I hereby certify that I attended the deceased from April 4 1943 to April 15 1943 that I last saw her alive on April 17 1943 and that death occurred on the date and hour stated above.
Immediate cause of death Heart failure Duration ✓

Due to Pneumonia ✓

Due to Hypertension

Other conditions IIIe
(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 Berlinand Shuman (M. D. or other) MD
Address Concordia Mo Date signed 4-18-43

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

5-1
00

MOTHER FATHER

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 *W Ray Green*.....

Licensed Embalmer No. *4305*.....

P. O. Address *Washington NW*.....

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.