

FILED JAN 14 1944
Registration District No. 739

Primary Registration District No. 5532

1. PLACE OF DEATH:

(a) County Holt Co. Mo
(b) City or town New Point Holt Co. Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Y X

(If not in hospital or institution, write street number or location)

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

In this community 20 years (years, months or days)

3. (a) PRINT FULL NAME Edward H. Laukemper

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary C. Laukemper 6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 24 1866 (Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days hr. min. If less than one day

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

10. Usual occupation farmer

11. Industry or business farm

12. Name Henry Laukemper

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

14. Maiden name Louise Kraft (City, town, or county) (State or foreign country)

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

16. (a) Informant Ether Schneider

(b) Address Oregon Mo

17. (a) Oregon (b) Date thereof 12-23-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Oregon

18. (a) Signature of funeral director David Urbain

(b) Address 5000 S. Main St. Springfield, Mo

19. (a) 12-23-43 (b) Pauline Dawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Holt 44

(c) City or town New Point (If outside city or town limits write "RURAL") 0

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 1943 hour 2 o'clock minute 0 M.

21. I hereby certify that I attended the deceased from July 10 1943 to Dec 20 1943 that I last saw him alive on Dec 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 6 months

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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? none (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 E. F. Kurney (M. D. or other)

Address Oregon Date signed 12/23/43

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

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,

J. Fred Terhune, Registered Apprentice No. *4279*
working under my personal supervision.

Signed *J. Fred Terhune*

Licensed Embalmer No. *1279*

P. O. Address *Savannah 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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *Holt*
(b) City or town *New Frank Hickory Twp*
(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)

3. (a) PRINT FULL NAME *Ed. H. Laukanger*

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 *m*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Oct. 24*
(Month) (Day) (Year)

8. AGE: Years *78* Months *3* Days _____ If less than one day _____ min.

9. Birthplace _____ (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 _____ (City, town, or county) (State or foreign country)
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) _____ (Date received local registrar) (b) _____ (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 *Dec* Day *26* year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____

that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-42442