

Registration District No. \_\_\_\_\_ Primary Registration District No. 3016

1. PLACE OF DEATH:  
(a) County: Lea  
(b) City or town: Jefferson City  
(c) Name of hospital or institution: St. Mary's Hospital  
(d) Length of stay: 1 week  
In this community # years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Mo. (b) County: Osage  
(c) City or town: Meta Mo.  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME: Mrs. Annie Grofe  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 29 year 1943 hour 3 minute a M.

4. Sex: Female 5. Color or race: white  
6. (a) Single, widowed, married, divorced: married  
6. (b) Name of husband or wife: Henry  
6. (c) Age of husband or wife if alive: 86 years  
7. Birth date of deceased: October 5-1864

21. I hereby certify that I attended the deceased from Dec 22, 1943 to Dec 29, 1943; that I last saw her alive on Dec 29, 1943; and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 2 Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: Labor pneumonia  
Due to: Osteomyelitis  
Other conditions: 108  
(Include pregnancy within 3 months of death)

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Major findings: Osteomyelitis of femur  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation: Housewife

11. Industry or business: \_\_\_\_\_  
12. Name: Gerhard Lueckenotte  
13. Birthplace: Germany  
14. Maiden name: Unknown  
15. Birthplace: Germany

16. (a) Informant: Les Grofe  
(b) Address: Meta Mo.

17. (a) Removal + Burial (b) Date thereof: Jan 1-1944  
(c) Place: burial or cremation: Meta Mo.

18. (a) Signature of funeral director: H. H. Drop  
(b) Address: Meta Mo.

19. (a) 12-30-43 (b) Thorne Richter  
(Date received local registrar) (Registrar's signature)

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. R. Alredy (M. D. or other) \_\_\_\_\_  
Address: Meta Mo. Date signed: 12/30/43

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

4525

**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.....

*H H Steep*

Licensed Embalmer No.....

*2924*

P. O. Address.....

*Meto 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.**