

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7523

FILED MAR 8 1944

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. _____

53
1
2

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

1. PLACE OF DEATH:

(a) County LACLEDE

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

(c) Name of hospital or institution:
WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 WKS. (Specify whether years, months or days)

In this community 3 WKS.

3. (a) PRINT FULL NAME LOUISE H ACKMAN

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CHAS. C. ACKMAN 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased AUG 14 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

34 6 4 hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

12. Name HENRY MACHENS

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

14. Maiden name CAROLINE DREYMAN

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

16. (a) Informant Chas C. Palmer

(b) Address ELDREDGE MO

17. (a) BURIAL (b) Date thereof 2 20 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOUBA CEM

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) MAR. 2-44 (b) Grace Popw
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE

(c) City or town ELDREDGE
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 18 year 1944 hour 3 minute 50 A.M.

21. I hereby certify that I attended the deceased from 12-13-1943 to 2-18-1944
that I last saw him alive on 2-18-1944
and that death occurred on the date and hour stated above.

Immediate cause of death Intentional obstruction Duration _____

Due to adhesions

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 R. E. Harrell (M. D. or other) MD

Address Lebanon, MO Date signed 2-19-44

1228 ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

1090

Received

Laclede County Health Unit

File No. 2-44-23

Date Filed 3/7/44

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 *Allyn Dethers*

Licensed Embalmer No. *4333*

P. O. Address *St. Louis 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.