

FILED OCT 21 1944
200

Registration District No. _____

Primary Registration District No. 2725

State File No. _____

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon, Rural Ill.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Steel Helms Ochsoph Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos
(Specify whether _____)
In this community 0
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 99th
(c) City or town Ottawa (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3. (a) PRINT FULL NAME Minnie Claus

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 Married
6. (b) Name of husband or wife Adam Claus 6. (c) Age of husband or wife if alive 1893 years
7. Birth date of deceased January 16 - 1893
(Month) (Day) (Year)

AGE	Years	Months	Days	If less than one day
	<u>71</u>	<u>7</u>	<u>23</u>	hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
12. Name Adolph
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Miller
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Adam Claus

(b) Address Ottawa Illinois

17. (a) removal (b) Date thereof Sept 10 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ottawa Ill

18. (a) Signature of funeral director Robert S. Krumm

(b) Address Macon

19. (a) 10/4/44 (b) John B. Kunkler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 9th
year 1944 hour 11 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 15, 1944, to September 9, 1944;
that I last saw h.e.r. alive on September 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 15 hrs.
Due to arteriosclerotic hypertension over 5 years

Due to _____
Other conditions Beginning hypostatic pneumonia 12 hrs.
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations Jzo
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)
(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 Robert B. Cass (M.D. or other) P.O.
Address S.H.O.S. Macon, Mo. Date signed 9/9/44

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

RECEIVED

District Health Officer No. 10

District File Number 10-44-1691

Date Filed OCT 7 1944

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 Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon 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.