

FILED NOV 20 1944

Registration District No. _____

Primary Registration District No. **5429**

1. PLACE OF DEATH:

(a) County **Franklin**

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

(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 **1**
(Specify whether years, months or days)

In this community **all**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**

(c) City or town **Rural**
(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 _____

3. (a) PRINT FULL NAME **LOUIS LOHMEYER**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **6**
year **1944** hour **11** minute **55 A.**M.

4. Sex **Male**

5. Color or race **W.**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **March 2 1883**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased **ONLY**
Oct. 6, 1944 to **1944**
that I last saw him alive on **Oct. 6,** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** **1 1/2 hrs.**

8. AGE:

Years	Months	Days	If less than one day
61	7	4	hr. _____ min. _____

Due to _____

Due to **940**

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

10. Usual occupation **Farmer**

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

11. Industry or business _____

12. Name **Henry Lohmeyer**

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

14. Maiden name **Minna Messerschmidt**

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Julius Lohmeyer**

(b) Address **Northaven**

17. (a) **Burial** (b) Date thereof **10-8-44**
(Burial method) (Month) (Day) (Year)

(c) Place: burial or cremation **Boylston Cem.**

18. (a) Signature of funeral director **H. Bertig, Jr.**

(b) Address **Northaven 9mo**

19. (a) **Oct 8-1944** (b) **Don Deese**
(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 **G. W. Held** (M. D. or other) **DO**

Address **New Haven, Mo.** Date signed **10/7/44**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-13-44

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

Earl Fertig

Licensed Embalmer No. 3385

P. O. Address New Haven

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.

Registration District No. 112

Primary Registration District No. 5429

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Rural Lyon Twp
(If outside city or town limits, write "RURAL" and name of township)
(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 Louis Lehmeier
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 3
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased March 2 (Month) (Day) (Year)

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

9. Birthplace New York (City, town, or county) (State or foreign country) no.

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct. 8-44 (b) Don Owens
(Date received local registrar) (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 _____ day _____ year 1944 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 _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

37695