S. No. 2
I—8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41092

FILED JAN 3/9 1945
Registration District No.

Primary Registration District No. 4192

Registrar's No. 8

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

7 0 0

1. PLACE OF DEATH:
(a) County Gasconade
(b) City or town Morrison
(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
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo ~~Morrison~~ (b) County Gasconade
(c) City or town Morrison 37
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME Louise Fredericka Diedriech

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 1

5. Color or race White 2

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 9 (Day) - 1862 (Year)

8. AGE: Years	Months	Days	If less than one day
82	7	5	hr. min.

9. Birthplace Callaway Co. (City, town, or county) 11 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Valentine Thomas
13. Birthplace Germany 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Wilhemina Monsell
15. Birthplace Germany 4 (City, town, or county) (State or foreign country)

16. (a) Informant Viola Diedriech
(b) Address Morrison, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Good Hope Cemetary

18. (a) Signature of funeral director Arnold Kummert
(b) Address Morrison, Mo

19. (a) Dec 16/44 (Date received local registrar) (b) G. H. Siedler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14th
year 1944 hour 4 minute 152 M.

21. I hereby certify that I attended the deceased from Sept 2nd, 1944 to Dec 14, 1944
that I last saw her alive on Dec 13, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death. Peripheral vascular collapse	indefinite
Due to Uremia	2 weeks
Due to Intestinal Obstruction by	3 weeks
Other conditions Carcinoma (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD
Address Morrison, Mo. Date signed 12/15/44

1261

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 1-2-45

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 August Blumm

Licensed Embalmer No. 3160

P. O. Address Hermann 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan 8

Registration District No. 319 Primary Registration District No. 4192 Registrar's No.

1. PLACE OF DEATH:
(a) County Gasconade
(b) City or town Morrison
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Lewis F. Diedrich
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 9 1861 (Month) (Day) (Year)

8. AGE: Years 82 | Months 7 | Days | If less than one day hrs. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
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)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 31 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to 46	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Carcinoma of Ascending Colon just above Caecum
Of autopsy

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

SUPPLEMENTAL INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. E. von Bastian (M. D. or other) 00
Address Morrison, Mo Date signed 1/5/45

41092