

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

FILED JAN 26 1945
199

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 2611 Charlotte
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XX (Specify whether
 In this community 58 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL") 2611 Charlotte 8
 (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 Jan. day 7th
 year 1945 hour 4: minute 45 A. M.

21. I hereby certify that I attended the deceased from Aug-8-1
1944 to Jan 7, 1945
 that I last saw her alive on Jan 5, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Abdominal Carcinomatosis Duration 5 mo
 Due to Carcinoma of uterus ?

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

Major findings: Generalized Abdominal Carcinomatosis PHYSICIAN _____
 Of operations _____ Underline the cause to which death should be charged statistically.
 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 0
 23. Signature E. Cristler (M. D. _____)
 Address 1002 Argyle Bldg. Date signed 1-8-45

3. (a) PRINT FULL NAME MRS. AMALIA LODDE

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

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frank Lodde 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased October 1 1868
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 3 6 hr. min.

9. Birthplace Baden Germany 4
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Karl Riehle

13. Birthplace Germany 4
 (City, town, or county) (State or foreign country)

14. Maiden name Barbara Falk

15. Birthplace Germany 4
 (City, town, or county) (State or foreign country)

16. (a) Informant Fred C. Lodde 1

(b) Address 319 East 70th Terrace

17. (a) Burial (b) Date thereof 1-10-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
Mt. St. Mary's

(c) Place: burial or cremation _____

18. (a) Signature of funeral director J. T. Wagner

(b) Address Kansas City, Mo.

19. (a) 1-9-45 (b) D. E. Brown
 (Date received local registrar) (Registrar's signature)

H
A
5037

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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.