S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 10 1945

Registration District No. 172

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5641

State File No. 13779

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: 3 mi. N.E. (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 Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette

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

(d) Street No. 3 mi. N.E. (If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME Anna Freitag Lefman

3. (b) If veteran, name war ---------

3. (c) Social Security No. ---------

4. Sex Fe

5. Color or race W

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

6. (b) Name of husband or wife August Lefman

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

7. Birth date of deceased Dec. (Month) 12 (Day) 1869 (Year)

8. AGE: Years 75 Months 4 Days 18 If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business

FATHER 12. Name Herman Freitag

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

MOTHER 14. Maiden name Fredriecka Starke

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

16. (a) Informant Homer Lefman

(b) Address Higginsville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director Forrest F. Tempel

(b) Address Lexington, Mo.

19. (a) 4-30-1945 (Date received local registrar) (b) Dr. W.A. Braeutigam (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30 year 1945 hour 6 minute 15 p. m.

21. I hereby certify that I attended the deceased from Apr. 17, 1945 to Apr. 30, 1945; that I last saw her alive on Apr 30, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Disease — many years.

Due to

Due to Carcinoma tongue (small) duration unknown

Other conditions (No cancer of tongue) No metastasis.
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 W. H. Leppenmeier (M. D. or other)

Address Higginsville Mo Date signed 5/3/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 5/9/45

MAR 2 1956

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 Forrest F. Turpel

Licensed Embalmer No. 3275

P. O. Address Lexington, 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.