

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

16709

Do not use this space.

1. PLACE OF DEATH

(a) County Dade Registration District No. 92
 (b) Township Lockwood Primary Registration District No. 5334
 (c) City or (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Carolina Boehne

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Never Married</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 19-1872</u>		
7. AGE <u>73</u>	YEARS <u>2</u>	MONTHS <u>7</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Houses Work</u>		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (CITY OR TOWN) <u>New Minden</u> (STATE OR COUNTRY) <u>Illinois</u>		
13. NAME <u>Christ Boehne</u>		
14. BIRTHPLACE (CITY OR TOWN) <u>Preuse Minden</u> (STATE OR COUNTRY) <u>Germany</u>		
15. MAIDEN NAME <u>Wilhelmina Lilienkamp</u>		
16. BIRTHPLACE (CITY OR TOWN) <u>Preuse Minden</u> (STATE OR COUNTRY) <u>Germany</u>		
17. INFORMANT <u>Ida Kottmeier</u> (ADDRESS) <u>Lockwood, Missouri</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Buried</u> <u>Immanuel Lutheran</u> DATE <u>April 19 1945</u>		
19. FUNERAL DIRECTOR (NAME) <u>A. L. Hamerschlag</u> (ADDRESS) <u>Lockwood, Missouri</u>		
20. FILED <u>May 3 1945</u> <u>Bernice M. Coe</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 26, 1945

22. I HEREBY CERTIFY, That I attended deceased from 1-14-, 1945 to 4-24-, 1945
 I last saw her alive on 4-24-, 1945 Death is said to have occurred on the date stated above, at 7 P. m.
 The principal cause of death and related causes of importance were as follows:
mitral stenosis

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) G. D. Combs, M. D.
 (Address) Lockwood Mo

RECEIVED

District Health Officer No. 6,

District File Number 645-640

Date Filed

JUN 7 1945

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

R. L. Hammerschild

Licensed Embalmer No. 3234

P. O. Address

Leaewood 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, above space should be left blank.