

7/11/45

FILED SEP 12 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 3020

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 109 - 8 Main St. - 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether)
In this community 80 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin
(c) City or town Washington - Mo. 6
(If outside city or town limits, write "RURAL")
(d) Street No. 109-8 Main (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EMILIE MARGARET BRECKENKAMP

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Aug. H. Breckenkamp 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased Apr 16 - 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 29 If less than one day
- hr. - min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name W. H. Otto
13. Birthplace Germany - 4
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Otto
15. Birthplace Germany - 4
(City, town, or county) (State or foreign country)

16. (a) Informant August Breckenkamp

(b) Address 1012 K. Rupwood Hwy. Burd -

17. (a) Burd - (b) Date thereof 8/18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Mo.

18. (a) Signature of funeral director Otto & Co

(b) Address Washington Mo.
19. (a) 8/16/45 (b) Shelley R. Brooks
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1945 hour 6:15 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from June 12
1945, to Aug 15, 1945

that I last saw h. or alive on Aug 15, 1945
and that death occurred on the date and hour stated above

Immediate cause of death Heart failure Duration _____

Due to Myocardial degeneration

Due to Age and arterio
sclerosis

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

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

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

23. Signature L. J. ... (M. D. or other) _____
Address 307 Jefferson Washington Date signed 8/16/45

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

6
6
2

1181

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 9-10-45

(SEP 2 1948)

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 _____

Licensed Embalmer No. 2464

P. O. Address Washington, 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.