No. 2
8-43
17-39
X37823

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. 27819

FILED SEP 13 1945

Registration District No. 38

Primary Registration District No. 3039

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline
(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
In this community 3 weeks
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

(c) City or town Marceline 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Bernard Anthony Lodder

3. (b) If veteran, name war World war 1

3. (c) Social Security No. 498-24-5747

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Elizabeth Barbour

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

7. Birth date of deceased February 21 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
53	5	25	hr. ..... min.

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

10. Usual occupation Gardnerer

11. Industry or business .....

FATHER
12. Name Rudolph Lodder
13. Birthplace — Germany
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Whelp
15. Birthplace — Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Helen Nanneman
(b) Address Hamden Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Mt Killiard

18. (a) Signature of funeral director James M Laughlin
(b) Address Marceline Mo

19. (a) 8-17-45 (Date received local registrar) (b) P L Patrick M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 16
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19...., to Aug 16, 1945;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Accidental Death	
Due to fall from Ferris Wheel	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 186 as 39
Of autopsy Remains Viewed

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) Accident 58

(b) Date of occurrence 8-16-45

(c) Where did injury occur? Marceline Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Carnival Cit. of Marceline Mo
(Specify type of place)

While at work? no (e) Means of injury Accident

23. Signature P. L. Patrick (M. D. or other)

Address Marceline Mo Date signed 8-17-45

135.0

(Licensed Embalmer's Statement on Reverse Side)

MAY 18 1955

AUG 5 1954

MAY 17 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 Dale Bunch

Licensed Embalmer No. 4088

P. O. Address Marceline Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 456 Primary Registration District No. 3039 Registrar's No.

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline
(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

In this community
years, months or days)

(a) PRINT FULL NAME Bernard A Lodder

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) 21 (Day) 1882 (Year)

8. AGE: Years 53 Months 5 Days 25 If less than one day hr. 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) 8-17-45 (Date received local registrar) (b) P. L. Patrick M.D. (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 16 year 1945 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.

Immediate cause of death

Due to

Due to

Other conditions
(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

Information supplied 6-1-46 P.L.P.

WRITE PLAINLY—USE UNFADING BLACK INK—M... CORD

S-27819