

FILED SEP 7 1945

Registration District No. 207

Primary Registration District No. 5758

State File No. _____

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Brinktown
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: my
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 57 yrs.
years, months or days

3. (a) PRINT FULL NAME Frances Lischwe

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Jacob Lischwe 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 19 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Frederick, Oregon (City, town, or county) (State or foreign country)

10. Usual occupation Home wife

11. Industry or business Farming

12. Name Henry Wieblich

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

14. Maiden name Josephine Wieblich

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

16. (a) Informant Joseph B. Lischwe

(b) Address Dixon, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Brinktown 8-28-1945

18. (a) Signature of funeral director H. H. [unclear]

(b) Address Meta, Mo.

19. (a) 8/27/45 (Date received local registrar) (b) Erma Bassett (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Marion (b) County Marion
(c) City or town Brinktown (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21 year 1945 hour 11 minute 10 A.M.

21. I hereby certify that I attended the deceased from August 14, 1945 to August 19, 1945 that I last saw her alive on Aug 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial insufficiency Duration 1 yr.
with cor. [unclear]
Due to chronic interstitial nephritis
Due to _____

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

Major findings: Of operations _____ 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) _____
23. Signature [unclear] (M. D. or other) 2 D.O.
Address Dixon, Mo. Date signed 8/27/45

(Licensed Embalmer's Statement on Reverse Side)

1096

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 9-6-45

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 H H Strop

Licensed Embalmer No. 2924

P.O. Address Meta 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.