

FILED NOV 6 1945

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town Washington Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
317 - E. 4th 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 34 yrs.
years, months or days

3. (a) PRINT FULL NAME CAROLINE MINNIE LOHSE

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 divorced

6. (b) Name of husband or wife Wm. Lohse
 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased June 12, 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 6
 If less than one day hr. - min.

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

10. Usual occupation Housewife

11. Industry or business ---

MOTHER FATHER
 12. Name William Bauck
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Wilhelmine Mueller
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Rabusch
 (b) Address Washington Mo.

17. (a) Burial (b) Date thereof Oct. 22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Mo.

18. (c) Signature of funeral director Chas. J. Co.

(b) Address Washington Mo.

19. (a) 10/23/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Franklin
 (c) City or town Washington
(If outside city or town limits, write "RURAL")
 (d) Street No. 317 E. 4th St.
(If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15
 year 1945 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from May, 1945 to Oct, 1945
 that I last saw her alive on Oct 15, 1945
 and that death occurred on the date and hour registered above.

Immediate cause of death Aspirated Pneumonia
 Due to Pericardial empyema

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)
 (e) Means of injury ---

23. Signature [Signature] (M. D. or other) ---
 Address Washington Mo. Date signed 10/29/45

Duration ---
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 11-5-45

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 *J. H. O.*

Licensed Embalmer No. 2764

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.