

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34650

State File No.

FILED NOV 3 1945  
Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2481

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Welston

(c) Name of hospital or institution:  
6402 Etzel Residence  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Nil (Specify whether  
In this community 5 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96

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

(d) Street No. 6402 Etzel Ave  
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME LIZZIE JANE LANTZ

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

3. (c) Social Security No. NIL

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Ira 6. (c) Age of husband or wife if alive Nil years

7. Birth date of deceased May 17 1861  
(Month) (Day) (Year)

8. AGE: Years 84 Months 5 Days 10

If less than one day hr. min.

9. Birthplace Cochockton Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name JACOB FREDLIN

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

14. Maiden name KATHERINE HOUCK

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

16. (a) Informant IRA HICKS

(b) Address 25, Sylevester Webster Groves

17. (a) REMOVAL (b) Date thereof 10-29-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. STERLING, IL.

18. (a) Signature of funeral director HOWARD F. ROWLAND

(b) Address 4355 WASHINGTON AV

19. (a) 18-30-45 (b) G. P. McNamee MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 27th  
year 1945 hour 9; minute 55 P.M.

21. I hereby certify that I attended the deceased from Jan 1942 to Oct 27th 1945  
that I last saw him alive on Oct 27th 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Dementia - Arterio Sclerosis

Due to 97

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) .....

(c) Means of injury 0

23. Signature Hudson Fellbatt MD (M. D. or other)

Address Metropolitan 309 Date signed 10-29-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

*Ronald Jahnke*

Licensed Embalmer No. *3917*

P. O. Address *St. Louis 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.**