

FILED JAN 17 1946
Registration District No. 1779

Primary Registration District No. 4266

1. PLACE OF DEATH:

(a) County Safayette
(b) City or town Wellington
(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 43 years years, months or days

3. (a) PRINT FULL NAME CHARLES E. LAUER

3. (b) If veteran, name war WW 3. (c) Social Security No. 70

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elana 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased July 21 1872 (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 9 If less than one day hr. min.

9. Birthplace Burlingame Kan (City, town or county) (State or foreign country)

10. Usual occupation miner

11. Industry or business

MOTHER FATHER
12. Name H. John Sauer
13. Birthplace Wergemia (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Raymond Sauer

(b) Address 4137 Cambridge Kansas City Kan

17. (a) Buried (b) Date thereof 1-1-46 (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Mo

18. (a) Signature of funeral director Ever Howard

(b) Address Wellington Mo

19. (a) Jan 2 1946 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Safayette
(c) City or town Wellington (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 Dec day 30 year 1945 hour 4 minute A M.

21. I hereby certify that I attended the deceased from April 8, 1945 to Dec. 22, 1945 that I last saw him alive on Dec. 22, 1945 and that death occurred on the date and hour stated above.
Immediate cause of death Pulmonary Edema Duration _____

Due to Mitral Insufficiency and Senility & debility

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 925

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 D. T. Kirby (M. D. or other) 280
Address Wellington Mo Date signed 12-31-45

WRITE PLAINLY—USE UNFADING INK

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-8-46

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. H 305

P. O. Address Washington Md

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.