

2-43
5-17-39
X35697

FILED JAN 14 1946

Registration District No. **363**

Primary Registration District No. **6236**

Registrar's No. **16**

1. PLACE OF DEATH:
 (a) County Warren
 (b) City or town Holstein-Rural-Charrette
 (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 88-3-5 years, months or days

3. (a) PRINT FULL NAME Anna Sophia Lichtenberg
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married, divorced, widow** widow
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased Sept. 11, 1857 (Month) (Day) (Year)

8. AGE: Years 88 Months 3 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Holstein Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Oberhellmann
13. Birthplace Germany Germany (City, town, or county) (State or foreign country)
14. Maiden name Sophia Bierbaum
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Frank of Lichtenberg
(b) Address Deloar. mo

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Dec 18 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Holstein, Missouri

18. (a) Signature of funeral director Fred Lichtenberg
(b) Address Marthasville, Missouri

19. (a) _____ **(b)** _____ (Registrar's signature)
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Warren
 (c) City or town Holstein Rural (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 15th year 1945 hour _____ minute 49 M.
21. I hereby certify that I attended the deceased from Dec 12 to Dec 16 1945
 that I last saw him alive on Dec 13 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Abn. Myocarditis
acute pneumonitis
Senility atherosclerosis
 Duration 2 yrs
State 3 days
10 years

Due to _____
 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) (b) Means of injury _____
23. Signature Herbert H Schumde (M. D. or other)
Address Marthasville Mo **Date signed** 12-17-45

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

MOTHER FATHER

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 *Fred W. Lichtenberg*

Licensed Embalmer No. *1321*

P. O. Address, *Merthasville*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 16

Registration District No. 363

Primary Registration District No. 6236

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Rural Charette Ferry
(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 _____ (Specify whether _____)
years, months or days

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 _____

3. (a) PRINT FULL NAME Anna S. Lichtenberg
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
4. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 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 _____
7. Birth date of deceased Sept 1 (Month) (Day) (Year)

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 88 Months 3 Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) Dec 18/45 (b) H. C. Johnson
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Date signed _____

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

SUPPLEMENTARY

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

42705