

FILED AUG 19 1946
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 222

Primary Registration District No. 4-333-5794

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Monteau

(b) City or town Rural Clarkburg
(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 _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monteau

(c) City or town 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 _____

3. (a) PRINT FULL NAME George Jacob Lachner

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1946 hour 8 minute A M.

21. I hereby certify that I attended the deceased from July 2, 1946, to Aug 9, 1946 that I last saw h. alive on Aug 8, 1946 and that death occurred on the date and how stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Oct 16 1868
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage Duration 1 day

Due to Generalized arteriosclerosis 10 years

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years 77 Months 9 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

Major findings: _____ Of operations ggs

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Geo Lachner

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

14. Maiden name Mary Ederg

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

16. (a) Informant Louis Lachner
(b) Address California Mo

17. (a) Burial (b) Date thereof 9-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cal. City Cemetery

18. (a) Signature of funeral director Willis L. Lumber
(b) Address 8/9/46

19. (a) 8-12-46 (b) Birdie Steugio
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place) _____ (e) Means of injury _____

23. Signature Keyson Latham (M. D. or other) _____
Address California Mo Date signed 8-10-46

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8
District File Number 8-46-156
Date Filed 8-13-46

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 *H. Friedmeyer*

Licensed Embalmer No. 2854

P. O. Address California 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.

Registration District No. 222

Primary Registration District No. 7303

1. PLACE OF DEATH:

(a) County moniteau
(b) City or town Rural Clarkburg Mo.
(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 _____
years, months or days)

3. (a) PRINT FULL NAME

George J. Lachner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

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 _____

7. Birth date of deceased Oct 16
(Month) (Day) (Year)

8. AGE:

Years 77

Months _____

Days _____

If less than one day _____

hr. _____ min. _____

9. Birthplace _____

(City, town, or county)

(State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day _____
year 1978 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

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) (c) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

27811