

FILED NOV 6 1946

Registration District No. 87

Primary Registration District No. 5212

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Clark Fork (Twp)
 (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: _____
 In this community 52 yrs 8 mos. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper
 (c) City or town Clark Fork Township
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ADDIE-ORR-LOTSPIECH

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 widowed
 6. (b) Name of husband or wife Charles H Lotspiech 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 20, 1860 (Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Carlisle Ky (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Same

MOTHER FATHER { 12. Name James Harvey Orr
 13. Birthplace Covington Ky (City, town, or county) (State or foreign country)
 14. Maiden name Margie McCormick
 15. Birthplace unknown Ky (City, town, or county) (State or foreign country)

16. (a) Informant Oris Lotspiech
 (b) Address Pilot Grove, Mo

17. (a) Burial (b) Date thereof Oct. 26, 1946 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pilot Grove cemetery

18. (a) Signature of funeral director Hays - Painter

(b) Address Pilot Grove, Mo

19. (a) 10-25-46 (b) Dr. J. Mendith (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 24 year 1946 hour 8:00 minute 05 P.M.

21. I hereby certify that I attended the deceased from Aug 15, 1946 to Oct 24, 1946 that I last saw her alive on Oct 23, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Disease of Heart
 Due to arteriosclerosis

Duration 7

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 90 D

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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. L. Mendenhall (M. D. or other) MD
 Address Prussia, Mo Date signed 10/24/46

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.....

myself....., Registered Apprentice No.....
working under my personal supervision.

Signed *R. L. Painter*.....
Licensed Embalmer No. *4069*.....
P. O. Address *Pilot Grove, Wis.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 83

Primary Registration District No. 5312

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Rural
(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 Adde O. Sotepiech

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

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 Oct 20
(Month) (Day) (Year)

8. AGE: Years 86 Months _____ 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 _____

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) 10-25-46 (b) [Signature]
(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 _____ Day _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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)
 (e) Means of injury _____

Signature _____ (M. D. or other)

Date signed 10/25/46

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

SUPPLEMENTARY

33115