

FILED NOV 27 1946  
Registration District No. **70**

Primary Registration District No. **5286412b**

Registrar's No. **69**

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

1. PLACE OF DEATH:

(a) County **Clark**  
(b) City or town **Wyaconda**  
(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 years, months or days)

3. (a) PRINT FULL NAME **Dr. M. La Freng**

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 **Single**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Aug 6 1897**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>49</b>	<b>2</b>	<b>12</b>	hr. _____ min.

9. Birthplace **Clark Co Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Joseph M. La Freng**  
13. Birthplace **Clark Co Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Armanda Krace**  
15. Birthplace **Scotland Co Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Elmer La Freng**

(b) Address **Wyaconda Mo**

17. (a) **Burial** (b) Date thereof **10-20-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wyaconda Bque**

18. (c) Signature of funeral director **Fred Charles**

(b) Address **Kahoka Mo**

19. (a) **Nov 4-46** (b) **J. H. Bridges**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clark**  
(c) City or town **Wyaconda**  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **18<sup>th</sup>**  
year **1946** hour **2** minute **P** M.

21. I hereby certify that I attended the deceased from **Oct 18** to **Oct 18** 19**46**  
that I last saw **or** alive on **Oct 18<sup>th</sup>** 19**46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremic Poisoning** Duration \_\_\_\_\_

Due to **Nephritis aged, Valvular heart disease**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations  Of autopsy  **92D**

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 **0**

23. Signature **F. M. Johnson** (M. D. or other) **MD**  
Address **Clark Mo** Date signed **10-2-46**

RECEIVED  
District Health Officer No. 10  
District No. 11: 46-2163  
Date Filed - NOV 26-1946

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 J Karle  
Licensed Embalmer No. 1023  
P. O. Address Kahoka 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.**