

FILED FEB 19 1948

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

4393

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 93
(b) Township Grant Primary Registration District No. 5333 Registered No. 9
(c) City 1 (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city & town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lara Kaelke

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Fe</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lara Kaelke</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 27-1874</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>7</u>	DAYS <u>3</u>
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Housewife</u>		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Horgenberg Switzerland</u>		
FATHER		
13. NAME <u>John Shearer</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Switzerland</u>		
MOTHER		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>Ralph Kaelke Lockwood, Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Lockwood, Mo</u> DATE <u>Feb 1</u> 19 <u>48</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>E. C. Caldwell Lockwood, Mo</u>		
20. FILED <u>2-2-48</u> 19 <u>48</u> <u>Leo J. Weir</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30 1948

22. I HEREBY CERTIFY That I attended deceased from Jan 25 1948, to Jan 25 1948
I last saw him alive on Jan 28 1948. Death is said to have occurred on the date stated above, at 4:00 a.m.
The principal cause of death and related causes of importance were as follows:
metastasis of liver
Date of onset not known

Other contributory causes of importance:

Name of operation H&Y Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), list in the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify H. D. Combs, M. D.
(Address) Lockwood, Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 6;
District File Number 248-253
Date Filed FEB 18 1948

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, & by.....

George Newcomb
working under my personal supervision.

Registered Apprentice No. 30

Signed E. Ray Caldwell

Licensed Embalmer No. 3380

P. O. Address Lockwood, 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, above space should be left blank.

6. 2B
3.45
X43880

Registration District No. 93 Primary Registration District No. 5003

1. PLACE OF DEATH:
(a) County Wade
(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 Lora Kaelke
3. (b) If veteran, name war _____ No. _____
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: June 2 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Switzerland (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)

16. (a) Informant _____
(b) Address _____

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

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(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 January Day 3 Year 1948 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 _____

In my opinion cause of death (was) from _____ of _____.
No biopsy or X Ray examination was made.
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 _____
23. Signature P. D. Combs (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

4393

J.D. Campbell
To: [unclear], Mr