

FILED MAR 15 1949
Registration District No. 174

Primary Registration District No. 3035

1. PLACE OF DEATH:
(a) County LA FAYETTE
(b) City or town LEXINGTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1718 MAIN ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community ALL HER LIFE
years, months or days (Specify whether)

3. (a) PRINT FULL NAME OTELIA A. HAERLE
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 F. RUDOLPH HAERLE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Sept 10 1864
(Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days 23 If less than one day hr. _____ min. _____

9. Birthplace: LEXINGTON MO
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN MEIERER
13. Birthplace GERMANY
14. Maiden name OTELIA WOLFER
15. Birthplace GERMANY

16. (a) Informant F. R. HAERLE

(b) Address LEXINGTON, MO

17. (a) BURIAL (b) Date thereof Nov 6, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEXINGTON MO

18. (a) Signature of funeral director F. R. TEMPEL

(b) Address LEXINGTON, MO

19. (a) 31 Dec 48 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County LA FAYETTE
(c) City or town LEXINGTON
(If outside city or town limits, write "RURAL")
(d) Street No. 1718 MAIN ST
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3
year 1948 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from 16 June 48
_____ 19____ to 3 Nov 48 19____

that I last saw her alive on 3 Nov 48 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Aneurysm
Duration _____

Due to arterio-sclerosis
Hypertension

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 _____

23. Signature Jesse Wadsworth (M. D. or other) _____
Address Lexington Mo Date signed 11/4/48

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 3-14-49

Ward

MAR 18 1949

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 Geo. J. Keane

Licensed Embalmer No. 2983

P. O. Address Lexington, Ma

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.