

FILED JUN 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16590

BIRTH NO. <u>134</u>		REG. DIST. NO. <u>206</u>		PRIMARY REG. DIST. NO. <u>5757</u>		Registrar's No. <u>34</u>	
1. PLACE OF DEATH a. COUNTY <u>Madison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural (St. Michaels Township)</u>		c. LENGTH OF STAY (in this place) <u>4 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 mi. S.W. of Fredericktown</u>				d. STREET ADDRESS (If rural, give location) <u>4 mi. S.E. of Fredericktown</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Anna</u>		b. (Middle) <u>Margaret</u>		c. (Last) <u>Lietz</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>May 16, 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	
8. DATE OF BIRTH <u>April 17, 1862</u>		9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington co. Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Antoine Wolff</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Elser</u>		14. NAME OF HUSBAND OR WIFE <u>Chas. Lietz. (deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hannah Trichel - Fredericktown Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 mo's</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 20</u> , 1949, to <u>May 16</u> , 1949, that I last saw the deceased alive on <u>May 16</u> , 1949, and that death occurred at <u>6:30 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. W. DeLeyne D.O.</u>				23b. ADDRESS <u>Fredericktown Mo.</u>		23c. DATE SIGNED <u>5/18/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/18/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Marcus Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Madison Co. Missouri</u>	
DATE REC'D BY LOCAL DEP. <u>5-26-1949</u>		REGISTRAR'S SIGNATURE <u>Florence Wickes</u>		197 FUNDING DIRECTOR'S SIGNATURE <u>L. T. Adamson</u>		ADDRESS <u>Fredericktown Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

62

RECEIVED

District Health Officer No. 4

District File Number 649-749

Date Filed 6-1-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Edward G. Lehmann

Signed _____
Student Embalmer

Licensed Embalmer No. 4567

P. O. Address Fredericktown, Md.

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.