

FILED MAR 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3753

BIRTH NO. _____ REG. DIST. NO. 31 PRIMARY REG. DIST. NO. 4040 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY Benton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Benton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cole Camp	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cole Camp	0020 A
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Claus	b. (Middle) Friederich	c. (Last) Lackman	4. DATE OF DEATH (Month) Feb (Day) 25th (Year) 1951
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 24th 1877	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Henry Lackman	13b. MOTHER'S MAIDEN NAME Margaret Schreoder	14. NAME OF HUSBAND OR WIFE Emma Lackman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs Josia Ehlers Cole Camp Mo	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH 334X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy DUE TO (c) Senility		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from 2-31, 1951, to 2-25, 1951, that I last saw the deceased alive on 2-24, 1951, and that death occurred at 11:40 am., from the causes and on the date stated above.

23a. SIGNATURE A. W. Moreland (Degree or title) Md.	23b. ADDRESS Cole Camp, Mo	23c. DATE SIGNED 2-26-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 28 1951	24c. NAME OF CEMETERY OR CREMATORY Mt Fulda	24d. LOCATION (City, town, or county) (State) Benton Missouri
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DATE REC'D BY LOCAL REG. Feb 26 1951	REGISTRAR'S SIGNATURE E L Eichhoff 394	25. FUNERAL DIRECTOR'S SIGNATURE E L Eichhoff	ADDRESS Cole Camp Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED 3-7-61
DISTRICT HEALTH OFFICE No. 3
District File Number -----
Date Filed 3-7-61 -----

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.

Student -----
Student Embalmer

Signed E. L. Eichhoff -----

Licensed Embalmer No. 730 -----

P. O. Address Cole Camp 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.