

Dr. Jeter

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22264

State File No. ....

BIRTH NO. FILED JUL 13 1953 REG. DIST. NO. 230 PRIMARY REG. DIST. NO. 4344 Registrar's No. 63

700

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

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b>  |  | 2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Gasconade</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Mc Kittrick</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Mc Kittrick, Mo.</b>  |  |
| c. LENGTH OF STAY (in this place) <b>6 yrs</b>  |  | d. STREET ADDRESS (If rural, give location) <b>0700</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION   |  |   |  |

|                                     |                         |                             |                           |   |
|-------------------------------------|-------------------------|-----------------------------|---------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Clara</b> | b. (Middle) <b>Margaret</b> | c. (Last) <b>Lohsandt</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>7 7 1953</b> |
|-------------------------------------|-------------------------|-----------------------------|---------------------------|---|

|                      |                               |   |                                   |   |                        |                      |                       |                      |
|----------------------|-------------------------------|---|-----------------------------------|---|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b> | 8. DATE OF BIRTH <b>9-12-1883</b> | 9. AGE (In years last birthday) <b>69</b> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | IF UNDER 24 HRS Hours | IF UNDER 24 HRS Min. |
|----------------------|-------------------------------|---|-----------------------------------|---|------------------------|----------------------|-----------------------|----------------------|

|  |  |   |   |
|--|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b> | 11. BIRTHPLACE (State or foreign country) <b>Missouri</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b> |
|--|--|---|---|

|                                     |   |  |
|-------------------------------------|---|--|
| 13a. FATHER'S NAME <b>Pete Hart</b> | 13b. MOTHER'S MAIDEN NAME <b>Mary Buecker</b> | 14. NAME OF HUSBAND, OR WIFE <b>Christian Lohsandt</b> |
|-------------------------------------|---|--|

|  |                                     |  |
|--|-------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Mac Saunders, Mc Kittrick, Mo.</b> |
|--|-------------------------------------|--|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br><b>7/3/53</b><br><b>15 yrs.</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral apoplexy</b>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerosis</b> |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <b>334X</b> | 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) (Min.) | 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 **6/25/53**, 19**53**, to **7/7/53**, 19**53**, that I last saw the deceased alive on **7/7/53**, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|   |                                |                                 |
|---|--------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>W. C. Jeter, M.D.</b> | 23b. ADDRESS <b>Hermann Mo</b> | 23c. DATE SIGNED <b>7/10/53</b> |
|---|--------------------------------|---------------------------------|

|   |                          |   |  |
|---|--------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>7-10-53</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Hermann City Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Hermann Mo.</b> |
|---|--------------------------|---|--|

|   |   |  |
|---|---|--|
| DATE REC'D BY LOCAL REG. <b>7-10-53</b> | REGISTRAR'S SIGNATURE <b>Mrs. Eunice Bush</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hermann, Mo.</b> |
|---|---|--|

JUL 16 1953

OCT 29 1953

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 Chas. M. Pope

Licensed Embalmer No. 2552

P. O. Address Hermann, 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.