

FILED NOV 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give town) Boonville		c. CITY OR TOWN Prairie Home	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 3 Weeks.		STREET ADDRESS (If rural, give location) Route 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital.			

3. NAME OF DECEASED (Type or Print) a. (First) Annie	b. (Middle) Brokamp	c. (Last) Lohse	4. DATE OF DEATH (Month) (Day) (Year) November 4 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 18 1882	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and State or Foreign Country) Cooper County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Brokamp.	13b. MOTHER'S MAIDEN NAME Marie ????	14. NAME OF HUSBAND OR WIFE Martin Lohse.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME Mrs. Raymond Huth,	ADDRESS Prairie Home, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis		
	DUE TO (c) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes 334X			

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) (Min.)	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 Oct 16, 1955, to Nov 4, 1955, that I last saw the deceased alive on Nov 3, 1955, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE M. L. DeGraegh M.D.	(Degree or title)	23b. ADDRESS Boonville Mo	23c. DATE SIGNED 11/7/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 7 1955	24c. NAME OF CEMETERY OR CREMATORY Clarks Fork	24d. LOCATION (City, town, or county) (State) Cooper County, Missouri.
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DATE REC'D BY LOCAL REG. 11/7/55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Goodman & Boller,	ADDRESS Boonville, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *William W. Wood*

Licensed Embalmer No. 45

P. O. Address Boonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.