

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23834**

FILED AUG 6 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 3011 Registrar's No. 64

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Carrollton</b>		c. CITY OR TOWN <b>Eugene Township</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Bales Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>R.F.D. 1 Wakenda</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Charles</b> b. (Middle) <b>Alfred</b> c. (Last) <b>Lautenschlager</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>August 1, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 14, 1900</b>
9. AGE (In years last birthday) <b>56</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Carroll Co., Mo.</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Fred Lautenschlager</b>		13b. MOTHER'S MAIDEN NAME <b>Dena Haselroth</b>	
14. NAME OF HUSBAND OR WIFE <b>Angie Wilson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>489-20-1364</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Charles Lautenschlager, Wakenda, Mo.</b> ADDRESS	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage left</b> <b>Malignant Hypertension</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Due to (b) Hypertension</b> <b>Due to (c) Nephritis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Weakness</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>10 years</b> <b>10 years</b>		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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 <b>7-26</b> , 19 <b>57</b> , to <b>8-1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-1</b> , 19 <b>57</b> , and that death occurred at <b>9:00</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Eugene P. Gales, M.D.</b> (Degree or title)		23b. ADDRESS <b>Carrollton Mo</b>	
23c. DATE SIGNED <b>8-2-57</b>		24. LOCATION (City, town, or county) (State)	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/4/1957</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Carroll Co., Missouri</b>	
DATE REC'D BY LOCAL REG. <b>8/4/57</b>		REGISTRAR'S SIGNATURE <b>Mrs. Herbert Calver</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Standley &amp; Gibson</b>		ADDRESS <b>Carrollton, Missouri</b>	

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

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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.....  
Signature of Student Embalmer

Signed *Morris D. Bailey*.....  
Licensed Embalmer No... *4800*

P. O. Address *Waverly*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.