

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037043

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 69

WENDED

1. PLACE OF DEATH a. COUNTY <u>Osage</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Osage</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Linn, Mo.</u>		Length of stay in lb <u>3Wks</u>	c. CITY OR TOWN <u>Freeburg, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manor Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>none</u> Last <u>Luecke</u>	4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Osage County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Mitchel Mengwasser</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Luecke</u>
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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></u>	17. INFORMANT Address <u>Joseph Luecke Freeburg, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>General arteriosclerosis</u>	
	DUE TO (c) <u>Glomerular nephritis chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u>
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21. I attended the deceased from 10-4-59 to 10-28-59 and last saw her/him alive on 10-28-59.
 Death occurred at 11:45AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph Luecke</u>	22b. ADDRESS <u>Linn</u>	22c. DATE SIGNED <u>11-2-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/2/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Scared Heart Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Richfountain, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Vienna, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-2-1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Cecylia Nelson</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Th. P. Birmingham

Licensed Embalmer No. 3664

P. O. Address Sumner

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.