

FILED SEP 26 1945

Registration District No. 46

Primary Registration District No. 4065

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Caldwell
(b) City or town Polo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)
In this community all his life years, months or days

3. (a) PRINT FULL NAME

Chas. Clarence Achenbach

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M. 5. Color or race wh 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lou. Etta Achenbach 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased July 21 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Polo (City, town, or county) Mo (State or foreign country)

10. Usual occupation Retired

11. Industry or business

12. Name Chas Achenbach
13. Birthplace Penn (City, town, or county) (State or foreign country)
14. Maiden name Louis Bartley
15. Birthplace Penn (City, town, or county) (State or foreign country)

16. (a) Informant Junior Achenbach
(b) Address Polo Mo
17. (a) Burial (b) Date thereof 9-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zionsville Cem.
18. (c) Signature of funeral director Abpaugh + Cowley
(b) Address Polo Mo

19. (a) Sept 11-45 (b) Corrine Garrett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell
(c) City or town Polo (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9 year 1945 hour 5 minute 20 P M.

21. I hereby certify that I attended the deceased from Aug 20 1945, to Sept 9 1945, that I last saw him alive on Sept 7 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhages Duration 3 days

Due to Pulmonary TB Long standing

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13F Of autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature C. H. ... (M. D. or other)
Address Polo Mo Date signed 9-10-45

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.