

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 17 1939

State File No. _____

Registration District No. 293

Primary Registration District No. 5411

Registrar's No. _____

1. PLACE OF DEATH: *Wm's*

(a) County Franklin.

(b) City or town Labadie, Mo. R.F.D. Boles Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Labadie, Mo. R.F.D. *2*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X 10 yrs.
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: *1*

(a) State Missouri. (b) County Franklin.

(c) City or town Labadie, Mo. R.F.D.
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? X _____ years.

3. (a) PRINT FULL NAME Ferdinand Fred Czeschin. 2571

3. (b) If veteran, name war X

3. (c) Social Security No. None.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6
year 1939 hour 5 minutes 15 P. M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of ~~husband's~~ wife Katharina Czeschin.

6. (c) Age of ~~husband's~~ wife if alive 60 years

7. Birth date of deceased January 9th, 1875.
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 6, 1939 to Dec. 6, 1939
that I last saw him alive on Dec 6, 1939
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>10</u>	<u>27</u>	hr. <u>X</u> min.

Immediate cause of death: Apoplexy

9. Birthplace Bland, Missouri.
(City, town, or county) (State or foreign country)

Due to _____

Due to g. h.

10. Usual occupation Farming.

Other conditions None
(Include pregnancy within 3 months of death)

11. Industry or business X

Major findings: Of operations _____

MOTHER FATHER { 12. Name Charles Czeschin. *6*

Of autopsy _____

18. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

Underline the cause to which death should be charged statistically

14. Maiden name Henrietta Schlottsch.

15. Birthplace Unknown Germany.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Katharina Czeschin

(b) Address Labadie, Mo. R. F. D.

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Dec. 9th, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Bland, Missouri.

(Specify type of place) _____

(e) Means of injury _____

18. (a) Signature of funeral director Nieburg & Witt, Inc. by Jester A. Witt

(b) Address Washington, Mo.

23. Signature J. P. Post (M. D. brother)

Address Washington Mo. Date signed 12/7/39

19. (a) 12-12-39 (b) Mary Czeschin
(Date received local registrar) (Registrar's signature)

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.....

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

Signed..... *Lester A. Pitt*

Licensed Embalmer No..... *3254*

P. O. Address..... *Washington, D.C.*

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, above space should be left blank.