

Registration District 1041 IV

Primary Registration District No. 5229

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural Lyon Mo

(c) Name of hospital or institution: Life on Farm

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME John W. Rosendahl

3. (b) If veteran name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W.

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

6. (b) Name of husband or wife Lena Rosendahl

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Aug. 8. 1884

8. AGE: Years 58 Months 7 Days 23

If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Leake Mo

(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

12. Name W. Rosendahl

13. Birthplace Germany

(City, town, or country) (State or foreign country)

14. Maiden name Christine Knehan

15. Birthplace Beaufort Mo

(City, town, or county) (State or foreign country)

16. (a) Informant Lena Rosendahl

(b) Address Leake Mo

17. (a) Burial (b) Date thereof Apr 3 1943

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beaufort Mo

18. (a) Signature of funeral director C. H. Stemme

(b) Address Beaufort Mo

19. (a) 3/31/43 (b) Stullman

(Date received in registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. Leake Mo. R. H. R.

(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 31

year 1943 hour 5 minute 2 M.

21. I hereby certify that I attended the deceased from Jan 14 1939 to Mar 31 1943

that I last saw him alive on Mar 30 1943

and that death occurred on the date and hour stated above.

Immediate cause of death Chrom Myocarditis

Duration 4 yrs

Due to \_\_\_\_\_

Due to 93d

Other conditions (Include pregnancy within 3 months of death)

Major findings: No operations

Of operations \_\_\_\_\_

Of autopsy No Autopsy

PHYSICIAN \_\_\_\_\_

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 J. H. Matthews M.D.

(D. or other)

Address Beaufort Mo Date signed 3/31/43

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

*E. H. Semme*

Registered Apprentice No.

working under my personal supervision.

Signed

*E. H. Semme*

Licensed Embalmer No.

*3076*

P. O. Address

*Beaufort, M.*

**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.