

FILED OCT 13 1944

State File No.

Registration District No. 79

Primary Registration District No. 53735379

Registrar's No. 233

## 1. PLACE OF DEATH:

(a) County DeKalb (Sherman) Mo  
 (b) City or town Amity (Rural)  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

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

(d) Length of stay: In hospital or institution 2 months  
(Specify whetherIn this community 2 months  
years, months or days)3. (a) PRINT FULL NAME Lourence Jane Folk

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced, Widowed6. (b) Name of husband or wife Jerry Folk 6. (c) Age of husband or wife if alive 17 years7. Birth date of deceased July 17 1878  
(Month) (Day) (Year)8. AGE: Years 66 Months 2 Days 9 If less than one day  
hr. min.9. Birthplace Clark Co. Ind. (City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business

12. Name George E. Snyder13. Birthplace Indiana (City, town, or county) (State or foreign country)14. Maiden name Mary E. Creamer15. Birthplace Indiana (City, town, or county) (State or foreign country)16. (a) Informant Eddard Snyder(b) Address Maysville Mo17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28-44  
(Month) (Day) (Year)(c) Place: burial or cremation Oak Lawn, Near Union Star Mo18. (a) Signature of funeral director Pilcher Funeral Home(b) Address Maysville Mo19. (a) 9-28-44 (Date received local registrar) (b) John Clarke (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeKalb  
 (c) City or town Maysville  
 (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 26 year 1944 hour 7 minute 30 a.m.21. I hereby certify that I attended the deceased from May 20 1944 to Sept 26 1944  
that I last saw h. alive on Sept 25 1944  
and that death occurred on the date and hour stated above.Immediate cause of death Coronary Occlusion

Due to

Due to

Other conditions Cholelithiasis June 1944  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of 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 Dr. Harold Paulsen (M. D. or other) D.O.Address Maysville Mo Date signed 9-28-44

**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.

Registration District No. 79

Primary Registration District No. 5879

1. PLACE OF DEATH:  
(a) County DeKalb  
(b) City or town Map Sherman Rural  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Lawrence J. Falk  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Sept Day 17 Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death coronary occlusion

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W  
(b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: July 17 (Month) (Day) (Year)  
8. AGE: Years 66 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Cholelithiasis June 1944  
(Include pregnancy within 3 months of death)  
Major findings: Chronic cholecystitis  
Of operations (not malignant)  
Of 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 [Signature] (M.D. or other) \_\_\_\_\_  
Date signed 10-18-46

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

SUPPLEMENTAL

MEDICAL CERTIFICATION

MOTHER FATHER

30823

*[Faint handwritten notes, possibly including "1911" and "1912"]*