

FILED DEC 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38801

State File No. 172

Registration District No. 172

Primary Registration District No. 4273

Registrar's No. 71

## 1. PLACE OF DEATH:

(a) County LAFAYETTE  
 (b) City or town CONCORDIA  
 (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 \_\_\_\_\_ (Specify whether)  
 In this community ALL HIS LIFE  
 years, months or days

## 3. (a) PRINT FULL NAME

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife LENA TIEMAN 6. (c) Age of husband or wife if alive 77 years  
 7. Birth date of deceased OCTOBER 18 1868  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 1 5 hr. min.

9. Birthplace EMMA, MO (City, town, or county) (State or foreign country) 0

10. Usual occupation RETIRED

11. Industry or business FARMER

12. Name AUGUST TIEMAN 0

13. Birthplace EMMA, MO (City, town, or county) (State or foreign country)

14. Maiden name MALINDA OETTING

15. Birthplace EMMA, MO (City, town, or county) (State or foreign country) 0

16. (a) Informant Mrs. L. P. Kramer

(b) Address KANSAS CITY, MO

17. (a) Burial (b) Date thereof Nov 27 1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation EVANGELICAL CEMETERY

18. (a) Signature of funeral director E. S. JAMES

(b) Address CONCORDIA, MO

19. (a) Nov 28 47 (b) Dayton N. Sandrum  
 (Date received local registrar) (Registrar's signature) 1517

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County LAFAYETTE 59  
 (c) City or town CONCORDIA  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 23  
 year 1947 hour 5 minute 30 AM/PM

21. I hereby certify that I attended the deceased from 5/20/47  
 to 11/23/47  
 that I last saw him alive on 11/23/47  
 and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis  
 Due to Bronchial Asthma  
 Due to Complicated by Fractured Hips.  
 Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 186 P  
 18  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Means of injury \_\_\_\_\_

23. Signature Dr. J. J. ... (City or town) (County) (State) MO  
 Address Concordia, Mo. Date signed 11/24/47

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

12-3-47

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

*E. S. James*

Licensed Embalmer No.

2058

P. O. Address

*Conradia, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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45  
3880

State File No. Dee  
Registrar's No. 171

Registration District No. 172

Primary Registration District No. 4273

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Concordia  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Martin Sieman

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 79 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
H. M. LISSACK, M.D. EDMUND LISSACK, M.D.  
Of autopsy \_\_\_\_\_  
DRE. LISSACK AND LISSACK CLINIC  
811 MAIN STREET CONCORDIA, MISSOURI TELEPHONE \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Nov 11/1947  
(c) Where did injury occur? Concordia, Mo  
(City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Fell in bathroom  
While at work? \_\_\_\_\_ (Specify if correct) \_\_\_\_\_  
(e) Means of injury hip fracture

23. Signature Edmund Probst (M.D. or other) \_\_\_\_\_  
Address Concordia, MO Date signed 11/11/47

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

SUPPLEMENTAL

38801

10/11

10/11  
10/11