

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36616

1 PLACE OF DEATH  
County Franklin  
Township.....  
or  
Village.....  
or  
City Pacific (NO..... St..... Ward)

Registration District No. 293 File No.....  
Primary Registration District No. 4177 Registered No. 52

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Koehler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED Married  
WIDOWED OR DIVORCED  
(Write the word)

6 DATE OF BIRTH July 22 1836  
(Month) (Day) (Year)

7 AGE 79 yrs. 5 mos. 1 ds. IF LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Carpenter  
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE  
(City or town, State or foreign country) Germany

PARENTS  
10 NAME OF FATHER Donot know  
11 BIRTHPLACE OF FATHER Germany  
(City or town, State or foreign country)  
12 MAIDEN NAME OF MOTHER Donot know  
13 BIRTHPLACE OF MOTHER Germany  
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Wolf  
(Address) Pacific Mo

15 Filed Dec 22, 1915 H.A. Booth  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 20 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 16 1915 to Dec 21 1915  
that I last saw him alive on Dec 21 1915  
and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
(Apoplexy) 64  
(Duration) yrs. mos. ds.  
82A  
CONTRIBUTORY Basilar ataxia  
(Secondary) above  
(Duration) yrs. mos. ds.

(Signed) H. Hoff M.D.  
Dec 21, 1915 (Address) Pacific Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Pacific City Cemetery DATE OF BURIAL 12/22/1915

20 UNDERTAKER Jno. A. Thibbes ADDRESS Pacific Mo

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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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.

PLACE OF DEATH

County Franklin

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Township \_\_\_\_\_ Registration District No. 293 File No. 36616  
 or \_\_\_\_\_  
 Village \_\_\_\_\_ Primary Registration District No. 4177 Registered No. 52  
 or \_\_\_\_\_  
 City Pacific (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Johns Koehler

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED Married  
 WIDOWED OR DIVORCED  
 (Write the word)

DATE OF DEATH Dec 20, 1916  
 (Month) (Day) (Year)

DATE OF BIRTH July 22, 1836  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 20, 1916, to Dec 20, 1916, that I last saw him alive on Dec 20, 1916.

AGE 79 yrs. 5 mos. 1 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

OCCUPATION (a) Trade, profession, or particular kind of work Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

The CAUSE OF DEATH\* was as follows: Apoplexy

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

PARENTS  
 NAME OF FATHER Do not know  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
 MAIDEN NAME OF MOTHER Do not know  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

Contributory Locomotor ataxia  
 (SECONDARY) Went 6  
 (Duration) yrs. mos. ds.  
 (Signed) Chas. Smith M. D.  
Dec 21, 1916 (Address) Pacific Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
 (Informant) Wm Wolf  
 (ADDRESS) Pacific Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
 Where was disease contracted If not at place of death?  
 Former or usual residence \_\_\_\_\_

Filed Dec 22 1916 W. B. Smith REGISTRAR

PLACE OF BURIAL OR REMOVAL Pacific City Cemetery DATE OF BURIAL 12/22, 1916  
 UNDERTAKER Geo. A. Thebes ADDRESS Pacific Mo

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