MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 40799

1 PLACE OF DEATH

County: Maries

Township: Jefferson — Registration District No. 5-41 — File No. 36

or

Village: — Primary Registration District No. 4321 — Registered No. 36

or

City: Belle (NO. ..... St. ..... Ward)

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

2 FULL NAME George Lehnhoff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov (Month) 13 (Day), 1887 (Year)

7 AGE: 30 yrs. 11 mos. 27 ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Belle Mo

PARENTS

10 NAME OF FATHER: J. P. Lehnhoff

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

12 MAIDEN NAME OF MOTHER: Henretta Heyde

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Chas Lehnhoff

(Address): Belle Mo

15 Filed: Nov 20, 1918. O. C. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 9 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 6, 1918, to Nov 9, 1918, that I last saw h. alive on Nov 8, 1918, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) 10 yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Johnson M. D.

Nov 9, 1918. (Address) Belle

*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: Heyde Cemetery

DATE OF BURIAL: Nov 11, 1918

20 UNDERTAKER: [illegible]

ADDRESS: Belle Mo

LOCAL REGISTRAR'S REPORT — DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If de
hospital
give it
of stre

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE .....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

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

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day

17 I HEREBY CERTIFY, that I attended d

....., 191....., to .....

that I last saw h.....alive on .....

and that death occurred, on the date stated above, a

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....m

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....m

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violen
(1) Means of Injury; and (2) whether Accidental, Suicidal o

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

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BU**

20 UNDERTAKER | **ADDRESS**

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE SECRETARY

GEO. H. JONES, M. D., SECRETARY, JEFFERSON CITY

T. H. WILCOXEN, M. D., BOWLING GREEN
T. W. COTTON, M. D., VAN BUREN