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.

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

Do not use this space.

V1408

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township — Primary Registration District No. 2001

City Springfield (No. 1003 Bennett St. Ward)

File No.

Registered No. 207

2. FULL NAME Wm H. Kahne

(a) Residence. No. 1003 Bennett St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Anna K. Kahne

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 16-1869

7. AGE 58

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
58	4	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ashland Ky
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER H. C. Kahne

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Nannie Bryant

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ashland Ky
(STATE OR COUNTRY)

14. INFORMANT Mrs. Anna K. Kahne
(Address) Springfield Mo.

15. FILED 4/2 1927 O C Horst MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/1 1927

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 4 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) ✓

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Thiss Shop?

DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ✓

(Signed) Jewell E. Windle Corner
4/1 1927 (Address) 534 St Louis St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Ashland Ky

DATE OF BURIAL: 4/ 1927

20. UNDERTAKER: Alma Lohmeyer Funeral Home

ADDRESS: SPRINGFIELD, MO.

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

Do not use this space.

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 207
City Springfield (No. ..... St. ..... Ward)

2. FULL NAME Wm. H. Kahne
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 16-1869

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
57	4	15	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 4/2 1927 O C Horst MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 1 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage of lungs
probably tuberculous, not from violence (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTAL

N. B.—Every item of information should be carefully supplied. AGE sho... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact st... of OCCUPATION

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