

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

Do not use this space.

8561

1. PLACE OF DEATH

County Vernon
Township Washington
City Canada

Registration District No. 875
Primary Registration District No. 6162

File No. _____
Registered No. 52
St. _____ Ward _____

2. FULL NAME Amos J. Kahro

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 31 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 0 14 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 173
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lake Creek, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER John N. Kahro

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

12. MAIDEN NAME OF MOTHER Margaret Vajen

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

14. INFORMANT wife, Nora Kahro
(Address)

15. FILED 3-6-31 E. P. King
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1931

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Feb 15, 1931
that I last saw him alive on Feb 14, 1931, and that death occurred, on the date stated above, at 1 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General paralysis of the Insane
34 (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Syphilis of Central Nervous System (duration) ? yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED ?
(IF NOT AT PLACE OF DEATH)

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) State Hosp. Staff - 3MB, M. D.

Feb 15, 1931 (Address) Nevada, Mo

*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 Smithton, Mo DATE OF BURIAL 2-17-31

20. UNDERTAKER Wyers Mortuary ADDRESS Nevada

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.

