

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

15956
Do not use this space.

REC'D MAY 24 1939

1. PLACE OF DEATH
 (a) County St Charles Registration District No. 913
 (b) Township Fernside Primary Registration District No. 5996B
 or Defiance
 (c) City Defiance (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Fred Kamphoefner
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 20-1890

7. AGE YEARS 48 MONTHS 5 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Mo

FATHER 13. NAME Fred Kamphoefner Sr. 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Mo

MOTHER 15. MAIDEN NAME Wilhelmine Weirich 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Charles Mo

17. INFORMANT (ADDRESS) Mrs Hulda Kamphoefner

18. BURIAL, CREMATION, OR REMOVAL PLACE Defiance DATE Apr. 21 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Morris Muschay Hamburg Mo

20. FILED 4-20-39 O P Gueneman 178 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-18 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows: _____

Other contributory causes of importance: 167

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? suicide Date of injury 4/18 1939. Where did injury occur? Defiance Mo (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. Manner of injury Shot him self with Nature of injury shotgun

24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) Joseph F. Mahon M. D. St. Charles Mo

APR 9 7 1945

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Morris Muschany*

Licensed Embalmer No. *2461*

P. O. Address *Hamburg N*

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

If this body is not embalmed, above space should be left blank.