

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

18583
 Do not use this space.

JUN 14 1939

1. PLACE OF DEATH
 (a) County Gasconade Registration District No. 303
 (b) Township Moark Primary Registration District No. 5420 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred 69 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME HERMAN HENRY KUHLMANN
 (a) Residence, No. Hermann, MO RFD 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 <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lena Kuhlmann</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 16, 1870</u>				
7. AGE YEARS		MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>69</u>		<u>3</u>	<u>8</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Farm</u>			
	10. Date deceased last worked at this occupation (month and year) <u>10/1/39</u>		11. Total time (years) spent in this occupation <u>40</u>	
12. BIRTHPLACE (CITY OR TOWN) <u>Hermann</u> (STATE OR COUNTRY) <u>MO</u>				
FATHER	13. NAME <u>William Kuhlmann</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>			
MOTHER	15. MAIDEN NAME (unkown) <u>Miller</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
17. INFORMANT <u>Mrs. Lena Kuhlmann,</u> (ADDRESS) <u>Hermann, MO RFD</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. George's Cem</u> DATE <u>5/27</u> 19 <u>39</u>				
19. FUNERAL DIRECTOR (NAME) <u>Hugo H. Blumer</u> (ADDRESS) <u>Hermann, Missouri</u>				
20. FILED <u>S-27</u> 19 <u>39</u> <u>Anna K. Riehoff,</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>May 24, 1939</u>	
22. I HEREBY CERTIFY, That I attended deceased from <u>Jan 1, 1939</u> , to <u>May 24, 1939</u> . I last saw him alive on <u>May 24, 1939</u> . Death is said to have occurred on the date stated above, at <u>10:30 a.m.</u> . The principal cause of death and related causes of importance were as follows: <u>Carcinoma of Prostate Gland</u> <u>Bladder Extension</u>	
Other contributory causes of importance:	
Name of operation <u>Cystectomy</u> Date of <u>Apr 24</u> . What test confirmed diagnosis? <u>_____</u> Was there an autopsy? <u>no</u>	
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____. Where did injury occur? _____ (Specify city or town, county, and State). Specify whether injury occurred in industry, in home, or in public place.	
Manner of injury _____ Nature of injury _____	
24. Was disease or injury in any way related to occupation of deceased? <u>no</u> . If so, specify _____ (Signed) <u>Hawari J. Korkman</u> , M. D. (Address) <u>Hermann, Mo.</u>	

57

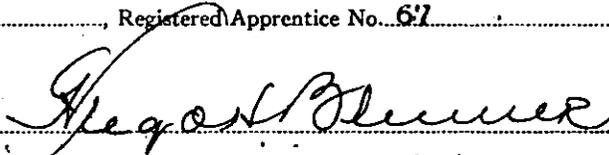
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....VICTOR J. TESSON JR....., Registered Apprentice No. 67

working under my personal supervision.

Signed.....



Licensed Embalmer No. 3160

P. O. Address Hermann, MO

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

18583
Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade Registration District No. 303
(b) Township Rock Primary Registration District No. 5420 Registered No. _____
(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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 Herman Berry Kuhlmann

(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-24-1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 3 8

The principal cause of death and related causes of importance were as follows:

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

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 51

Carcinoma of prostate
metastatic to bladder
and rectum

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

Other contributory causes of importance:

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Carcinoma Bladder
Carcinoma Rectum
Both secondary to Prostate

Name of operation Colostomy Date of _____
What test confirmed diagnosis? Pathology Was there an autopsy? no

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19____ Local Registrar.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Howard Hartman, M. D.

(Address) Hermann

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

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.

SUPPLEMENTARY

