

1230 JUN 13 1939

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

19117
Do not use this space.

1. PLACE OF DEATH
(a) County LINN Registration District No. 503
(b) Township PARSON CREEK Primary Registration District No. 5669
(c) City _____ (d) Street No. _____ Registered No. 209
(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.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME 600 JOHN W. KEHR
(a) Residence, No. MEADVILLE MO 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 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 CLARA KEHR
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG. 17/1865
7. AGE YEARS 73 MONTHS 9 DAYS 17 If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION 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) MILLER CO. MISSOURI
FATHER 13. NAME RENHOLD KEHR
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DONT KNOW UNITED STATES
MOTHER 15. MAIDEN NAME LUCY SWELLING
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DONT KNOW UNITED STATES
17. INFORMANT (ADDRESS) C. E. KEHR MEADVILLE MO
18. BURIAL, CREMATION, OR REMOVAL PLACE ELDON MO WOOD BERT DATE MAY 30, 1939
19. FUNERAL DIRECTOR (ADDRESS) SMILEY FUNERAL HOME WHEELING MO
20. FILED 5-19 1939 E. J. Weir Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17 1939
22. I HEREBY CERTIFY, That I attended deceased from Oct 24 1938 to May 17 1939
I last saw him alive on May 16 1939. Death is said to have occurred on the date stated above, at 8:30 P. m.
The principal cause of death and related causes of importance were as follows:
Carcinoma of Bronchus + Lung ✓
Date of onset _____
Other contributory causes of importance: 47
Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no
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) J. W. H. Puffer M. D. DO
(Address) Brownfield mo
1152

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

RECEIVED

District Health Officer No. 441

District File Number 39-600

Date Filed JUN 5 1935

STATEMENT BY LICENSED EMBALMER

I, Frank L. Smiley, Licensed Embalmer No. 470
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Frank L. Smiley

L. E.
No. _____ or by _____ Registered Apprentice No. _____
working under my personal supervision.

Signed Frank L. Smiley
Licensed Embalmer No. 470

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

1917
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 503
(b) Township Parson Creek Primary Registration District No. 5669
(c) City _____ (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 209

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
John W. Reber
(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) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 9 17

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 _____

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

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-17-1917

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:

Carcinoma of Bronchi & Larynx
Primary Site Larynx
Date of onset 3-12-18

Other contributory causes of importance:

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? _____ 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? _____

If so, specify _____

(Signed) H. H. Pettey, M. D.

(Address) Brookfield mo

SUPPLEMENTARY

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.

