

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31849

Registration District No. 71

Primary Registration District No. 5110A

Registrar's No. 31

1. PLACE OF DEATH: 2
(a) County Boone
(b) City or town Cedar Lap RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John H. Althoff 431

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife MARTHA Ellis Althoff 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased August 27 1885
(Month) (Day) (Year)

8. AGE: Years 54 Months X Days 21 If less than one day hr. min.

9. Birthplace MONITEAU Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business "

12. Name Frank Althoff

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name SOPHIA Kirchhoff

15. Birthplace MONITEAU Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Martha Althoff

(b) Address Columbia R 3

17. (a) Burial (b) Date thereof Sept 29 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Salem

18. (a) Signature of funeral director Rev. Weller

(b) Address Columbia, Mo

19. (a) 9/6/39 (b) Francis Nichols
(Date filed and local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route 8
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — Life — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18th
year 1939 hour 10 minute 4 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Unknown

Chronic

Due to 82th

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury _____

23. Signature W.P. Tashen (M. D. or other) 7

Address 2157 8th Date signed 9/19/39

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, ~~only~~ *me*

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

Signed *Lyman W. Sprinkle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia, 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.