

Registration District No. 306

Primary Registration District No. 5424

Registrar's No. 14

1. PLACE OF DEATH:  
(a) County. GASCONADE  
(b) City or town. RURAL BOEUF TOWNSHIP  
(c) Name of hospital or institution:  
OWENSVILLE ROUTE 1  
(d) Length of stay: In hospital or institution. 86 YRS.  
In this community 86 YRS.

2. USUAL RESIDENCE OF DECEASED:  
(a) State. MISSOURI (b) County. GASCONADE  
(c) City or town. RURAL  
(d) Street No. OWENSVILLE ROUTE 1  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JOHN WILLIAM KAHLE  
3. (b) If veteran, name war. NO  
3. (c) Social Security No. NONE

4. Sex. M  
5. Color or race. W  
6. (a) Single, widowed, married, divorced. SINGLE  
6. (b) Name of husband or wife. NONE  
6. (c) Age of husband or wife if alive. \_\_\_\_\_ years  
7. Birth date of deceased. MARCH 25 1853

8. AGE: Years 86 Months 7 Days 24  
If less than one day hr. \_\_\_\_\_ min.

9. Birthplace. OWENSVILLE ROUTE 1 MO.  
10. Usual occupation. FARMER

MOTHER FATHER  
11. Industry or business. 1  
12. Name. CHRISTIAN KAHLE  
13. Birthplace. GERMANY  
14. Maiden name. MARGARET SCHOENEBAUM  
15. Birthplace. GERMANY

16. (a) Informant's own signature. Carl Schenck  
(b) Address. Owensville MO 21  
17. (a) BURIAL (b) Date thereof. 11-27-34  
(c) Place: burial or cremation. LUTHERAN CEM. DRAKE MO

18. (a) Signature of funeral director. W.F. Dettmer  
(b) Address. Owensville Mo  
19. (a) 11-27-34 (b) John Engelbrecht  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 day 22  
year 1939 hour 8:30 minute 9 M.  
21. I hereby certify that I attended the deceased from 8-10-1939 to 71-22-1939  
that I last saw him alive on 11-20-1939  
and that death occurred on the date and hour stated above.

Immediate cause of death. Angina Pectoris  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions. \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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? \_\_\_\_\_  
(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 \_\_\_\_\_  
Signature. Edward Mellis (M. D. or other) \_\_\_\_\_  
Address. Owensville Mo Date signed 11-22-39

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.

**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 me

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

Miford H H Wint

Licensed Embalmer No. 3838

P. O. Address Owensville 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.**