DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 - 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6545

Registration District No. 297 Primary Registration District No. 3016 Registrar's No. 25

1. PLACE OF DEATH:

(a) County Franklin.

(b) City or town Washington, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 428 W. Third St. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No. (Specify whether

In this community 50 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Washington (If outside city or town limits, write "RURAL")

(d) Street No. 428 W. Third St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? x years.

3. (a) PRINT FULL NAME 65-2 Henry George Kohring.

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of ~~husband or~~ wife Sophia Kohring.

6. (c) Age of ~~husband~~ or wife if alive 61 years

7. Birth date of deceased Apr. (Month) 24th. (Day) 1869. (Year)

8. AGE:

Years	Months	Days	If less than one day
70	9	24	hr. x min.

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

10. Usual occupation Shoe-worker.

11. Industry or business x

FATHER
12. Name Henry Kohring.
13. Birthplace Unknown. (City, town, or county) Germany. 6 (State or foreign country)

MOTHER
14. Maiden name Eliza Farwig.
15. Birthplace Union, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Mrs Lester Oberhaus

(b) Address 701 S. Jefferson St. Washington, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1940 near Krakow, Mo (Month) (Day) (Year)

(c) Place: burial or cremation Mantels Cemetery.

18. (a) Signature of funeral director NIEBURG & VITT, Inc. by

(b) Address Washington, Mo. A. J. Nieburg

19. (a) Feb. 19-1940 (Date received local registrar) (b) H. A. May (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 18th year 1940. hour 2 minute 05 P. M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw him alive on Feb. 18, 1940, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Apoplexy	
Due to Hypertension & Diabetes Mellitus	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations
Of autopsy

PHYSICIAN — 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? (City or town) (County) (State)

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

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) 1

Address Washington, Mo Date signed 2/19/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19511

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 A. J. Meiburg

Licensed Embalmer No. 2387

P. O. Address Washington, 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.