

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38

MAY 13 1940

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Luxington
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME WILLIAM OCHEL SR.

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

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

6. (b) Name of husband or wife Anna Harms 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 2 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 1 10 hr. _____ min.

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

10. Usual occupation Blacksmith

11. Industry or business Retired

12. Name Karl Ochel

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

14. Maiden name Wilhelmine Hoffmann

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev. Aug. Bueggeman

(b) Address Hudson, Kan.

17. (a) Removal (b) Date thereof April 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hudson, Kan.

18. (a) Signature of funeral director Wissler

(b) Address Luxington, Mo.

19. (a) April 13 (b) Delia J. Sales
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Stafford

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

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th
year 1940 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from not at all, 19____, to _____, 19____;

that I last saw him alive on not at all, _____, 19____;

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

Immediate cause of death Acute cause
dilatation

Due to Chronic Enterocolitis

Due to _____

Other conditions (include pregnancy within 3 months of death) not

Major findings: Of operations _____

Of autopsy _____

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? _____

896 While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature A. J. Kland (M. D. or other) _____

Address Luxington, Mo. Date signed 4/12/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5/10/40

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 _____

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

Signed Geo. A. McKeon

Licensed Embalmer No. 2983

P. O. Address Lexington, 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.