

MAY 15 1940

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **120**

1. PLACE OF DEATH

(a) County **WYOMING - Washington**
 (b) City, or town **PURRA - Washington**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **State Hosp #3**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **26 days**
(Specify whether in this community years, months or days) **4 22 known**

3. (a) PRINT FULL NAME **Henry Pahlman**

8. (b) If veteran, name war **422 K 220 W 7** 8. (c) Social Security No. **422 K 220 W 7**

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

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

7. Birth date of deceased **UNKNOWN**
(Month) (Day) (Year)

8. AGE: **About 84** Years Months **UNKNOWN** Days _____ If less than one day hr. _____ min.

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

10. Usual occupation **laborer**

11. Industry or business **UNKNOWN**

12. Name **Bernard Pahlman**

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

14. Maiden name **Lena Fiedman**

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

16. (a) Informant **Hospital Records**

(b) Address **State Hosp #3 Nevada mo**

17. (a) ~~Burial~~ (b) Date thereof **4/21/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis, Mo.**

18. (a) Signature of funeral director **Marck Dehinger**
 (b) Address **Nevada mo.**

19. (a) **4/21/40** (b) **Allen V. Hays**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St. Louis City**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **477 K 21 W 7**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? **About 80** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **20**
 year **1940** hour **9** minute **40 A. M.**
 21. I hereby certify that I attended the deceased from **2-26-40**
 19**40**, to **4-20**, 19**40**
 that I last saw him alive on **4-20**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis**

Due to **92C**

Other conditions **General Arteriosclerosis**
(Include pregnancy within 3 months of death)

Major findings: **0**
 Of operations _____
 Of autopsy _____

Duration _____
 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?

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

23. Signature **[Signature]** (M. D. or other) _____
 Address **State Hosp #3** Date signed **4/29/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 7,
District File Number 5-40-737
Date Filed 5-6-40

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 Mark Eichen
Licensed Embalmer No. 2656
P. O. Address Newaday M

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.