

Registration District No. _____ Primary Registration District No. 5642 Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Lewis High
- (b) City or town Rural
- (c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)
- (d) Length of stay: In hospital or institution _____
(If not in hospital or institution, write street number or location)
- In this community Five years
years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Theodore Geohl 407

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

 4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

 6. (b) Name of husband or wife Annie Geohl 6. (c) Age of husband or wife if alive 69 years

 7. Birth date of deceased June 23 - 1869
(Month) (Day) (Year)

 8. AGE: Years 72 70 Months 10 Days 12 If less than one day _____ hr. _____ min.
9. Birthplace Quincy Ill
(City, town, or county) (State or foreign country)10. Usual occupation Farming

11. Industry or business _____

12. Name John Geohl
 13. Birthplace Germany
(City, town, or county) (State or foreign country)

 14. Maiden name Julia
(City, town, or county) (State or foreign country)
16. (a) Informant's own signature Julia Temp(b) Address 1426 Elm, Quincy Ill.
 17. (a) Burial (b) Date thereof May 14 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Caring18. (a) Signature of funeral director Thomas Ball(b) Address Ewing, Mo
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____
(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 MAY day 11
year 1940 hour 7 P minutes 40 P. M.

 21. I hereby certify that I attended the deceased from MAY 10, 1940, to MAY 11, 1940
that I last saw him alive on MAY 11, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death ANBILIA PECTORIS Duration _____Due to ARTERIO SCLEROSIS

Due to _____

 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

 Underline
the cause to
which death
should be
charged sta-
tistically.

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? _____

 987
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature W. E. Ellinger M.D. (M. D. or other) _____Address Quincy Mo Date signed 5/14/40

RECEIVED

District Health Officer No. 10

District File Number 6-40-1238

Date Filed JUN 12 1948

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 Thomas Ball

Licensed Embalmer No. 1749

P. O. Address Evony, Md

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 18885-7

Registration District No. 478

Primary Registration District No. 5642

Registrar's No.

1. PLACE OF DEATH:

(a) County. Lewis
(b) City or town. Highland T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Theodore Geoble
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced. m
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year
7. Birth date of deceased June - 28 - 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 12
If less than one day hr. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) July 15 - 1940 (b) P. W. Jennings (c) (Water received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.
(c) City or town. (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.

20. DATE OF DEATH. Month May day 11
year 1940 hour minute M.
MEDICAL CERTIFICATION

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.

Due to.

Due to.

Other conditions. (Include pregnancy within 3 months of death)

Major findings: 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 W. L. Ellers (M. D. or other)

Address La. Orange St. Date signed.

SUPPLEMENTAL ENTRY

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

S-18885