

Registration District No. **318**

Primary Registration District No. **5439**

Registrar's No. **528**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
Springfield R.R. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **16 years**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield R.R. 1**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 11.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charles D. Bohmstedt**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Lara O'Bannon Bohmstedt** 6. (c) Age of husband or wife if alive **Dead** years

7. Birth date of deceased **Feb 2 1872**
(Month) (Day) (Year)

8. AGE: Years **69** Months **4** Days **28** If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Luise Bohmstedt**

13. Birthplace **Unknown** (City, town or county) **N.Y.** (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Leah Bohmstedt**

(b) Address **Springfield R.R. 1**

17. (a) **Burial** (b) Date thereof **July 3 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **First Church**

18. (a) Signature of funeral director **Over Funeral Home**

(b) Address **629 W Walnut City**

19. (a) **7-3-41** (b) **H. E. Handley MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **30**
year **1941** hour **5** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **6-30-1941** to **6-30-1941**;
that I last saw him alive on **6-30-1941**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia with Effusion of Pleural Cavity**
Previous attack of **None**

Due to _____
Due to _____

Other conditions (Include pregnancy within 8 months of death) **None**

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?

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

23. Signature **W. Ellis** (M. D. or other) **C**

Address **Springfield Mo** Date signed **7-3-41**

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

MOTHER FATHER

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.....

Hayd W Lee

Licensed Embalmer No. *2910*

P. O. Address *629 W Walnut*

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, fact should be so stated above.