

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25141  
Do not use this space.

FILED AUG 15 1941

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
(b) Township Springfield, Mo Primary Registration District No. 2001 Registered No. 611  
(c) City Springfield, Mo (d) Street No. Springfield Baptist Hosp. St. \_\_\_\_\_  
(If death occurred in hospital or institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William F. Kollmeier

(a) Residence, No. \_\_\_\_\_ St.  Lockwood, Mo  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Husband of Bertha Kollmeier  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12, 1874  
7. AGE YEARS 1 66 MONTHS 7 DAYS 13 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Veneday Ill

FATHER 13. NAME William Kollmeier

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Carolina Krefit

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Tobias Kiefer Lockwood, Mo.

18. BURIAL, CREMATION, OR REMOVAL Burial  
PLACE Grant township DATE 7-28 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. L. Hunschild Lockwood, Mo.

20. FILED 726 1941 W. E. Handley md Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25, 1941

22. I HEREBY CERTIFY, That I attended deceased from July 21, 1941, to July 25, 1941  
I last saw him alive on July 25, 1941. Death is said to have occurred on the date stated above, at 12:30 P.M.  
The principal cause of death and related causes of importance were as follows:

Ruptured Spleen  
apudectis  
12/1

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Harris Smith M. D.  
(Address) Springfield, Mo

**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. 3234

working under my personal supervision.

Signed R. L. Hamschild

Licensed Embalmer No. 3234

P. O. Address Laurel 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.**