

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 14 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

5742

Registration District No. \_\_\_\_\_ Primary Registration District No. 200 Registrar's No. 74

1. PLACE OF DEATH:  
(a) County Adair  
(b) City or town Millard with limits  
(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 \_\_\_\_\_ (Specify whether)  
In this community all his life years, months or days

2. USUAL RESIDENCE OF DECEASED: Adair  
(a) State Missouri (b) County Adair  
(c) City or town Millard (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.

3. (a) PRINT FULL NAME Jacob Kohlman  
(b) If veteran name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day second year 1942 hour 1:30 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Feb 15 1942 to Feb 27 1942 that I last saw him alive on Feb 27 1942 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race W. 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife ora 6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased 10-11-1859 (Month) (Day) (Year)

Immediate cause of death Hypostatic pneumonia Duration \_\_\_\_\_  
Due to Chronic myocardiosis  
Due to arteriosclerosis & senility

8. AGE: Years 82 Months 4 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

10. Usual occupation farmer  
11. Industry or business \_\_\_\_\_  
12. Name Jacob Kohlman  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Anna Kohlman  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. W. Bragg  
(b) Address Kirkville Mo. 645  
17. (a) Burial (b) Date thereof 3-4-42 (Month) (Day) (Year)  
(c) Place: burial or cremation St. Marys Cemetery  
18. (a) Signature of funeral director Ed. Hopper  
(b) Address St. Louis  
19. (a) Mar 3 1942 (b) Wm. J. Wagner (Date received local registrar) (Registrar's signature)

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 Wm. C. Kelly (M. D. or other) DO  
Address 911 E. Patterson, Kirksville, Mo. Date signed 3-3-42

RECEIVED

District Health Officer No. 10

District File Number 10-42-398

Date Filed \_\_\_\_\_

MAR 11 1942

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 1

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County Osair  
(b) City or town Millard  
(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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Jacob Rohlmayer  
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 Oct 11 185  
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 19  
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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month Mar day 2  
year 1992 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to ypostatic Pneumonia  
Bronchopneumonia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_ 107

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 Wm J Kelly (M. D. or other) MD

Address Likerville, Missouri Date signed 3-1-92

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SUPPLEMENTARY

S-5742