

FILED MAY 14 1942

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1821**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Research**
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution **30 days** (Specify whether years, months or days)

In this community **32 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kans** (b) County **Miami**

(c) City or town **Paola**
(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 _____

3. (a) PRINT FULL NAME **Irene Koehler**

3. (b) If veteran name war **no**

3. (c) Social Security No. **none**

4. Sex **Female**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **S. A. Koehler**

6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **Oct. 3, 1891**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
50	7	5	hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **John Ross Col**

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

14. Maiden name **Addie Elds**

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

16. (a) Informant **S. A. Koehler**

(b) Address **Paola, Kans**

17. (a) **Removal** (Burial, cremation, or removal)

(b) Date thereof **5-10-42**
(Month) (Day) (Year)

(c) Place: burial or cremation **Paola, Kans**

18. (a) Signature of funeral director **J. M. Meyer**

(b) Address **Paola, Mo**

19. (a) **5-8-42** (Date received local registrar)

(b) **M. M. Cronin** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **8th** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **March 1941** to **May 8 1942** that I last saw **her** alive on **May 8 1942** and that death occurred on the date and hour stated above.

Immediate cause of death **Hodgkins disease**

Duration **3 months**

Due to **44B**

Other conditions **Peptic ulcer of stomach chronic**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **as above**

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? _____

(Specify type of place) _____

While at work _____ (e) Means of injury **1)**

23. Signature **Leo Knappenberger M.D.** (M. D. or other) _____
Regyle Bldg. May 8-42
Address _____ Date signed _____

SEP 6 1949

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.