

**FILED AUG 7 1943**  
Registration District No. **144**

Primary Registration District No. **4233**

Registrar's No. **2**

**1. PLACE OF DEATH:**

(a) County **Iron**  
(b) City or town **Arcadia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Arcadia College and Wendline Academy**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community **Twenty-one years**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Iron**  
(c) City or town **Arcadia**  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Sister Christine Kohlberg**

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

4. Sex **Female** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **March 8 1865**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **3** Days **9** If less than one day hr. min.

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business.....

12. Name **Henry Kohlberg**

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

14. Maiden name **Elizabeth Tiffe**

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

16. (a) Informant **Mother Carmelita, D.S. G.**

(b) Address **Arcadia, Mo.**

17. (a) **Burial** (b) Date thereof **June 19, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Arcadia, Mo.**

18. (a) Signature of funeral director **Norman White & Sons**

(b) Address **Fronton Mo.**

19. (a) **7-26-43** (b) **Virginia C. Muller**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **June** day **17<sup>th</sup>**  
year **1943** hour **2:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **June 15<sup>th</sup>** 19**43**, to **June 17** 19**43**  
that I last saw **the** alive on **June 17** 19**43**  
and that death occurred on the **date** and hour stated above.

Immediate cause of death.....  
**Acute Bi-lateral Bronchial Pneumonia**

Due to.....  
**Chronic Bronchitis - 7?**

Due to.....  
**Chronic myocarditis??**

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

Major findings: Of operations.....  
**930**

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) (c) Means of injury.....  
23. Signature **P. E. Harland** (M. D. or other)  
Address **Fronton Mo.** Date signed **7/19/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 843-25

Date Filed 8-6-43

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**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

*Arnell White*

Licensed Embalmer No. 3012

P. O. Address. *Denton, 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, fact should be so stated above.**