

No. 2
5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 13 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38852
State File No. _____
Registrar's No. 129

Registration District No. _____ Primary Registration District No. 3040

1. PLACE OF DEATH:
(a) County Lickington
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Chillicothe Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lickington
(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 517 - Elm St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME Dr. Frank B. Jahr
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 14
year 1943 hour 7:00 minute 19 M.
21. I hereby certify that I attended the deceased from last 1942 to Nov 14 1943
that I last saw him alive on Nov 14 1943
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary E. Wilson Jahr 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 12 - 1864
(Month) (Day) (Year)

Immediate cause of death Hypostatic pneumonia 3 days
Chronic myocarditis ?
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

8. AGE: Years 79 Months 8 Days 2 If less than one day _____ hr. _____ min.
9. Birthplace Dresden Germany
(City, town, or county) (State or foreign country)
10. Usual occupation Dentist - Retired

11. Industry or business Dentistry
12. Name Frank A. Jahr
13. Birthplace unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown Germany
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mary Wilson Jahr
(b) Address Chillicothe Mo.
17. (a) Burial (b) Date thereof 11 - 16 - 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington, Mo.
18. (a) Signature of funeral director James Gordon
(b) Address Chillicothe Mo.
19. (a) Nov 16 (b) LoUELLA CERRY
(Date received local registrar) (Registrar's signature)

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 P. D. Brennan (M. D. or other) _____
Address Chillicothe, Mo. Date signed 11/15/43

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

MOTHER FATHER

MAR 1 1944

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 *James D Gordon*
Licensed Embalmer No. *1870*
P. O. Address *Phillippo M*

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.