

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 409

94
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FILED MAR 10 1944
Registration District No. 1944

Primary Registration District No. 6075

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington Rural St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Ms. State Hospital No. 40
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 10 day
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford 94

(c) City or town Cuba
(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 HERMAN L. KELHOFF

3. (b) If veteran, name war _____

3. (c) Social Security No. 499-03-1997

4. Sex M 5. Color or Race W

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

6. (b) Name of husband or wife Clara Herrow

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Sept. 7 - 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>4</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation Gardener

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mr. Herman Kelhoff

(b) Address Cuba Mo

17. (a) Burial (b) Date thereof 1-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cuba Mo

18. (a) Signature of funeral director Albert Edging

(b) Address Bourbon Mo.

19. (a) Feb. 9, 1944 (b) Tyndie Buhmester
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24, year 1944 hour 10: minute 00 P. M.

21. I hereby certify that I attended the deceased from December 14, 1943 to Jan. 24, 1944 and that I last saw him alive on January 24, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Central atherosclerosis

Due to _____

Due to _____

Other conditions 83a1
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 0

23. Signature M. Langhans (M. D. or other) med

Address 408 W. Third Date signed 2-4-44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1196

RECEIVED

District Health Officer No. 4

District File Number 344-347

Date Filed 3-7-4

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

Albert E. Long

Licensed Embalmer No.

3504

P. O. Address

Bourbon 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.