

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 10 1944

Registration District No. 184

Primary Registration District No. 3032

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Johnson

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

(c) Name of hospital or institution:
201 Broad St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NO
30 Yrs (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")

(d) Street No. 201 Broad St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sophia Carolin Krohn

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex Female 5. Color or race White

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: June 8 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

84	9	10	hr. min.
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9. Birthplace Linn Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER

12. Name Peter Krohn

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

14. Maiden name Fredrika Gove

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

16. (a) Informant Frank Krohn

(b) Address Warrensburg, Mo

17. (a) Burial (b) Date thereof 3-20-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg, Mo.

19. (a) March 20, 1944 (b) Scale M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 18
year 1944 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 1
15 to March 18 1944
that I last saw her alive on March 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Terminal typhoid
static pneumonia

Due to deaculitis from
pyelocystitis, and
Due to fracture right hip

Other conditions: hemiplegia; arterio-
sclerosis.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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) 1051

(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 5

23. Signature W. D. ... (M. D. or other) _____

Address Warrensburg, Mo. Date signed 3-20-44

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

1001

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..... *Earl Priest*

Licensed Embalmer No..... **3878**

P. O. Address..... **Warrensburg, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Johnson
 (b) City or town Warrensburg
(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

Sophia C. Kuhn

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

June
(Month)

8
(Day)

1951
(Year)

8. AGE:

Years 84

Months _____

Days _____

If less than one day _____ min.

9. Birthplace _____

(City, town, or county)

Mo.
(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) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

(Date received local registrar)

(b) _____

(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day _____
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that I met her _____ alive on _____, 19____;
 and the death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____

Due to _____

Due to fell out of bed

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

Major findings:
 Of operations _____

Of autopsy _____

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) no
 (b) Date of occurrence _____
 (c) Where did injury occur? Her home, Warren
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Fell out of bed.
(Specify type of place)
 While at work? no (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed 4-13-44

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

MOTHER FATHER

SUPPLEMENTARY

11-10-78

11298