

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Levering Hospital
(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 Fred W. Kahl

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, Divorced Widowed
6. (b) Name of husband or wife Susan Heileman 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased April 16, 1966
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 11 8 ..hr. ..min.

9. Birthplace Hannibal Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Baker

11. Industry or business Retired

MOTHER FATHER { 12. Name Henry Kahl
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Fredericka Stecker
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. George Digel
(b) Address 1524 Lyon Street
17. (a) Burial (b) Date thereof 3/26/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olivet
18. (a) Signature of funeral director Wm M. Smith
(b) Address 902 Broadway Hannibal Missouri
19. (a) 3-28-44 (b) R. W. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 1524 Hannibal Lyon
(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 24
year 1944 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from March 15, 1944 to March 24, 1944
that I last saw him alive on March 23, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Due to arterio sclerosis

Other conditions (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.....
23. Signature J. H. Ardelt (M. D. or other)
Address Hannibal Mo Date signed 3-24-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *George T. Bond*

Licensed Embalmer No..... 4373

P. O. Address 902 Broadway Hannibal 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. may
Registrar's No. 1100

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:
(a) County marion
(b) City or town Hannibal
(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) (Specify whether

3. (a) PRINT FULL NAME Fred. W. Kahl
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 16 1881
(Month) (Day) (Year)
8. AGE: Years 47 Months 11 Days _____ Unless than one day _____ min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (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 24
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis
(2) arterio sclerosis
Due to _____
Due to _____

Other conditions _____ (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) (c) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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