

5. No. 2
-1-4-41
5-17-39
P1 X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34196

State File No. _____

FILED NOV 4 1944
Registration District No. 179

Primary Registration District No. 4192

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Morrison
(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) 1
(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community. _____ years, months or days)

3. (a) PRINT FULL NAME BERNHARD KUHLMANN
3. (b) If veteran, name war ✓ 3. (c) Social Security No. 702-14-507

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 30 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 10 20 _____ hr. _____ min.

9. Birthplace HERMANN Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Rail Worker

11. Industry or business _____

MOTHER FATHER { 12. Name Wm Kuhlmann 4

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

14. Maiden name Sophie Mueller

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

16. (a) Informant Alvin Kuhlmann

(b) Address Morrison Mo.

17. (a) Burial (b) Date thereof 10-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morrison Mo.

18. (a) Signature of funeral director Arnold Hammer

(b) Address Morrison Mo.

19. (a) Oct. 18/44 (b) A. H. Siedler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade 37
(c) City or town Morrison 0
(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 _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15th
year 1944 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from 10/15/1944 to 10/15/1944
that I last saw him alive on 10/15/1944
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory Collapse Duration Minutes

Due to Coronary Occlusion Minutes

Due to Arteriosclerosis Indefinite

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

Major findings: Of operations PHC 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) _____

(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) Means of injury _____

23. Signature C. E. Vondashian (M. D. or other) 2

Address Morrison, Mo. Date signed 10/16/44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-3-44

W. H. H. H.
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.....

Licensed Embalmer No..... 3160

P. O. Address..... Meriden Conn

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.