

**1. PLACE OF DEATH:**  
 (a) County **Franklin**  
 (b) City or town **Rural Sherrel**  
 (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** **Louis C. Kofahl**  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_  
**4. Sex** **M** **5. Color or** **W** **6. (a) Single, widowed, married,** divorced **Married**  
**6. (b) Name of husband or wife** **Leon Kofahl** **6. (c) Age of husband or wife if** \_\_\_\_\_ years  
**7. Birth date of deceased** **April 14 1865**  
 (Month) (Day) (Year)

**8. AGE:** Years **80** Months **9** Days **14** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
**9. Birthplace** **Sherrel Mo.** (City, town, or county) (State or foreign country)  
**10. Usual occupation** **Farming**  
**11. Industry or business** \_\_\_\_\_  
**12. Name** **Christopher Kofahl**  
**13. Birthplace** **Germany** (State or foreign country)  
**14. Maiden name** **Mary**  
**15. Birthplace** **Germany** (State or foreign country)  
**16. (a) Informant** **L. C. Kofahl**  
**(b) Address** **Bakersfield Calif.**  
**17. (a) (b) Date thereof** **2-3-46**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Shales Cem**  
**18. (a) Signature of funeral director** **W. H. Ferguson**  
**(b) Address** **Livington Mo.**  
**19. (a) Feb. 1, 1946** **(b) Mrs. Elvora Hesse**  
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo** (b) County **Texas**  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. **34 Mi N E of Temple Mo** (If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Jan** day **28** year **1946** hour **12** minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** **Jan 25** to **Jan 28** 19 **46**  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **burn on left arm**  
 Due to **Infection**  
 Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
**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) \_\_\_\_\_ **107**  
 (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** **L. S. Randall** (M. D. or other) **MD**  
 Address **Livington Mo** Date signed \_\_\_\_\_

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

RECEIVED

District Health Officer No. 5;

District File Number 246137

Date Filed 2. 6. 46

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 Erbert Ferguson

Licensed Embalmer No. 3945

P. O. Address Lehigh 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.

Registration District No. 353

Primary Registration District No. 696

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Shelburne  
(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 Louis C. Kofahl

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 M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr 14 1909  
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER { 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) \_\_\_\_\_  
(Data 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 Jan Day 21 Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? at home  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes  
Tell on stove  
(Specify type of place) Means of injury \_\_\_\_\_

23. Signature Lester Sandall (M. D. or other) \_\_\_\_\_

Address Licking MO Date signed 2-13-46

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

SUPPLEMENTARY

4312