

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 26 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 325

Primary Registration District No. 4479

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Queencity Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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 Adam Kuhn

3. (b) If veteran,

name war None

3. (c) Social Security

No. _____

4. Sex Male

5. Color or

race White

6. (a) Single, widowed, married,

2 divorced Widower

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased _____

(Month)

13

(Day)

1870

(Year)

8. AGE:

Years

Months

Days

If less than one day

23 76

5

3

hr.

min.

9. Birthplace Near Queencity

Missouri

(City, town, or county)

(State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Same

12. Name Michael Kuhn

13. Birthplace Forn Born Place

Not Known

(City, town, or county)

(State or foreign country)

14. Maiden name Mary Berg

15. Birthplace Germany

(State or foreign country)

16. (a) Informant Michael Kuhn

(b) Address Queencity MO

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Mar. 18 1947

(Month) (Day) (Year)

(c) Place: burial or cremation Queencity Cemetery

18. (a) Signature of funeral director Wm M West

(b) Address Queencity MO

19. (a) Mar 22 1947

(Date received local registrar)

(b) Wm M West

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler
(c) City or town Queencity
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 16
year 47 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 was found dead

Probably caused by death
due to chronic
due to chronic
Due to _____

Due to _____

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) _____

(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 Wm M West (Date or other) 20

Address Queencity MO Date signed 3-17-47

(Licensed Embalmer's Statement on Reverse Side)

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

353

RECEIVED
District Health Officer No. 10
District File Number 3-42565
Date Filed MAR 25 1947

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 self
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Wm H West
Licensed Embalmer No. 2882

P. O. Address Lucency 910

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.