

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

FILED FEB 18 1948

State File No. _____

Registration District No. 119

Primary Registration District No. 4193

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Hermann
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
108 Schiller St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 97 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME AUGUST CLEMENS BOEHM

3. (b) If veteran, name war none 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Cora Boehm 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 14 1850
(Month) (Day) (Year)

8. AGE: Years 97 Months 3 Days 17 If less than one day hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name John Boehm

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

14. Maiden name (unknown) Horstman

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

16. (a) Informant Paul Boehm

(b) Address Hermann, Mo

17. (a) Burial (b) Date thereof 1-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hermann City Cemetery

18. (a) Signature of funeral director Hugo Stueck

(b) Address Hermann, Mo

19. (a) 1/3/48 (b) H. M. Muehler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade 37
(c) City or town Hermann
(If outside city or town limits, write "RURAL")
(d) Street No. 108 Schiller St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1st 1948
year _____ hour _____ minute 3 P. M.

21. I hereby certify that I attended the deceased from Dec. 26th 1947 to Jan 1st 1948
that I last saw him alive on Jan 1st 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Pneumonia

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 E. S. Rhodius (M. D. or other) _____

Address Hermann, Mo Date signed 1/2/48

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause of death which should be reported statistically.

2/12/68

Date

Dist.

District Health Officer No. 9

RECEIVED

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.....

working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. 3160

P. O. Address. Hermann, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 1

Registration District No. 119

Primary Registration District No. 4193

1. PLACE OF DEATH: Gasconade
 (a) County.....
 (b) City or town..... Bermann
 (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 August C. Boehn
 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 wid
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased Sept 14 (Month) (Day) (Year)

8. AGE: Years 97 Months Days (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 FATHER { 12. Name
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name (State or foreign country)
 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..... year 1947 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above. (Immediate cause of death)

lobar pneumonia
 Due to.....
 Due to.....
 Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations..... 108
 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 E.G. Rhodius (M. D. or other).....
 Address Bermann MO Date signed 3/3/48

4463

Wesleyan, Ind

E. J. R. R. R.