

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40866

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 1130

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY OR TOWN <u>RURAL N. CAMPBELL</u> <small>(If rural, write RURAL and give township)</small>		c. CITY OR TOWN <u>RURAL N. CAMPBELL</u> <small>(If rural, write RURAL and give township)</small>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>R.F.D. # 10 SPRINGFIELD</u> <small>(If not in hospital or institution, give street address or location)</small>		d. STREET ADDRESS <u>R.F.D. # 10</u> <small>(If rural, give location)</small>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JACOB</u>	b. (Middle)	c. (Last) <u>COHNEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 19, 1949</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>SINGLE III</u>	8. DATE OF BIRTH <u>2 MARCH 1870</u>	9. AGE (In years last birthday) <u>79</u>	10. UNDER 1 YEAR Months	11. UNDER 1 WEEK Hours	12. UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>PETER COHNEN</u>	13b. MOTHER'S MAIDEN NAME <u>CECTRUDE BUNKMAN</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. SALLY JOHNSON</u>	18. ADDRESS <u>Rt. 10 SPEED MO.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio-Sclerosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		<u>450c</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 11-3-1946 to 12-19-1949, that I last saw the deceased alive on 12-19-1949, and that death occurred at 11:00 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. Kelly M.D.</u> (Degree or title)	23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>12-20-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>12-22-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN CEME.</u>	24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD MO.</u>
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DATE REC'D BY LOCAL REG. <u>12-20-49</u>	REGISTRAR'S SIGNATURE <u>W.E. Handley, M.D.</u>	FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Ringler & Co.</u>	ADDRESS <u>Springfield Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 9 1958

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Max Rhodes

Signed _____

Student Embalmer

Licensed Embalmer No. 4071

P. O. Address Springfield

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.