

FILED SEP 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **29401**

BIRTH NO. _____		REG. DIST. NO. <b>38</b>		PRIMARY REG. DIST. NO. <b>3006</b>		Registrar's No. <b>239</b>	
1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Boone</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Columbia</b>		c. LENGTH OF STAY (in this place) <b>44 yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Columbia</b>		d. STREET ADDRESS (If rural, give location) <b>509 S. 5th</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hosp.</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b> b. (Middle) <b>LEE</b> c. (Last) <b>KOHR'S</b>			4. DATE OF DEATH (Month) <b>9</b> (Day) <b>15</b> (Year) <b>1950</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>10-23-1905</b>	
9. AGE (In years last birthday) <b>44</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Columbia, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Thomas A. Cathy</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret E. Whitaker</b>		14. NAME OF HUSBAND OR WIFE <b>William Kohrs</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>William Kohrs 509 S. 5th Columbia, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension arterial</b> DUE TO (c) <b>Propter mollities</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 Hours</b> <b>Unknown</b> <b>321X</b> <b>?</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)			
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?			
22. I hereby certify that I attended the deceased from <b>9-15-1950</b> , to <b>9-15-1950</b> , that I last saw the deceased alive on <b>9-15-1950</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Frank E. Palmer, M.D.</b> (Degree or title)				23b. ADDRESS <b>Columbia, Mo.</b>		23c. DATE SIGNED <b>9-16-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9-18-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Columbia, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>Sept 19 1950</b>		REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Parsons Funeral Service, Columbia, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

RECEIVED 9/26/50  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed 9/26/50

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.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Thomas L. Daring*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4132

P. O. Address *Columbia, S.C.*

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.