

## STANDARD CERTIFICATE OF DEATH

32950

State File No. ....

FILED NOV 5 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 69 PRIMARY REG. DIST. NO. 5270 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <u>CHRISTIAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CHRISTIAN</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>"RURAL" LINCOLN</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>"RURAL" LINCOLN</u>	
c. LENGTH OF STAY (in this place) <u>50 YRS.</u>		d. STREET ADDRESS (If rural, give location) <u>RT #1, BILLINGS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RT #1, BILLINGS</u>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>ALBERT</u>	b. (Middle) <u>WILHELM</u>	c. (Last) <u>BOHM</u>	(Month) <u>OCT.</u>	(Day) <u>19</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 16-1872</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>FREDRICK BOHM</u>	13b. MOTHER'S MAIDEN NAME <u>AMELIA KRUGER</u>	14. NAME OF HUSBAND OR WIFE <u>MINNIE ZELL BOHM</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. MINNIE BOHM</u> ADDRESS <u>RT. #1, BILLINGS, Mo.</u>

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY THROMBOSIS</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) <u>4201</u> (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 6:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>John Dean Harris</u>	(Degree or title) <u>3rd Corner Christian Co. Clergyman</u>	23b. ADDRESS <u>Cleves, Mo.</u>	23c. DATE SIGNED <u>OCT. 19-1951</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>OCT. 22-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS EVANGELICAL CHRISTIAN Co.</u>	24d. LOCATION (City, town, or county) (State) <u>Mo.</u>
DATE REC'D BY LOCAL REG. <u>Oct. 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Allina Lewis</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John Dean Harris</u> ADDRESS <u>Cleves, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

~~DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield  
RECEIVED NOV 2 1951  
Dist. File \_\_\_\_\_  
Date Filed \_\_\_\_\_~~

~~DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield  
RECEIVED NOV 2 1951  
Dist. File \_\_\_\_\_  
Date Filed \_\_\_\_\_~~

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield  
RECEIVED NOV 2 1951  
Dist. File 4390  
Date Filed 11-3-51

**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.

Student .....  
Student Embalmer

Signed John Alan Harris  
Licensed Embalmer No. 4390  
P. O. Address Cleveland, 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.