

No. 300
10. 48

FILED DEC 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39846

State File No.

BIRTH NO. _____ REG. DIST. NO. 328 PRIMARY REG. DIST. NO. 4492 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>ORAN</u>	c. LENGTH OF STAY (in this place) <u>1 yr.</u>	c. CITY OR TOWN <u>ORAN</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ORAN</u>		No. STREET ADDRESS (If rural, give location) <u>ORAN</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u>	b. (Middle)	c. (Last) <u>KIELHOFNER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 25 1954</u>
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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>DECEMBER 25 1927</u>	9. AGE (In years last birthday) <u>26</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKERY</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>PASTERY</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>PERKINS, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>EMIL KIELHOFNER</u>	13b. MOTHER'S MAIDEN NAME <u>CHRISTINE SSGHOTT</u>	14. NAME OF HUSBAND OR WIFE <u>LOUISE KIELHOENER</u>
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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>487-32-2524</u>	17. INFORMANT'S SIGNATURE OR NAME <u>LOUISE KIELHOENER</u>	ADDRESS <u>ORAN, MO.</u>
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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>CARDIAC DECOMPENSATION</u>		<u>3 DAYS</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERPYREXIA, ANEMIA</u> DUE TO (c) <u>HODGKIN'S DISEASE</u>		<u>6 WKS.</u> <u>4 YRS</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>PNEUMONITIS, ILEUS</u>		<u>3 WKS</u>	

19a. DATE OF OPERATION <u>1953</u>	19b. MAJOR FINDINGS OF OPERATION <u>LYMPHATIC GLANDS PROVED HODGKIN'S DISEASE</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NATURAL</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>NONE</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>NONE</u>	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>NONE</u>
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22. I hereby certify that I attended the deceased from 11-8, 1954, to 11-24, 1954 that I last saw the deceased alive on 11-24, 1954, and that death occurred at 8:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. J. Mosebach, D.O.</u>	23b. ADDRESS <u>Chaffee</u>	23c. DATE SIGNED <u>11-26-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>NOV. 27 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NEW GUARDIAN ANGELS</u>	24d. LOCATION (City, town, or county) (State) <u>ORAN MO.</u>
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DATE REC'D BY LOCAL REG. <u>11-29-54</u>	REGISTRAR'S SIGNATURE <u>Pro Fred Berg...</u>	445	25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl J. Smith</u>	ADDRESS <u>ORAN, MO.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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DATE RECEIVED **NOV 29 1954**
SCOTT CO. HEALTH DEPT.
CO. FILE NO. **1154-248**

DEC 8 1954

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,
Signature of Student Embalmer

Signed *Carl J. Smith*

Licensed Embalmer No. *2476*

P. O. Address *Quincy, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.