

FILED SEP 10 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27802**  
Registrar's No. **339**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3052**

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Sedalia</b>		c. LENGTH OF STAY (in this place) <b>65 Yrs.</b>	c. CITY OR TOWN <b>SEDALIA</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>901 East 6th, St.</b>		STREET ADDRESS (If rural, give location) <b>901 E 6th. 280/10</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>BENJAMIN</b>	b. (Middle) <b>FRANKLIN</b>	c. (Last) <b>KAHRS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 1, 1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 18, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maint. Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. State Hwy. Dept. Lake Creek, Mo.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>U.S.A.</b>

13a. FATHER'S NAME <b>Peter Kahrs</b>	13b. MOTHER'S MAIDEN NAME <b>Margretha Schleusing</b>	14. NAME OF HUSBAND OR WIFE <b>Wayme Ellis Kahrs</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>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Wayme Kahrs, Sedalia, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Terminal Pneumonia. 48 Hours.</b>		INTERVAL BETWEEN ONSET AND DEATH
	2. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cardio-Vascular Disease Over ten yrs.</b> DUE TO (c) <b>Old Hemiplegia. 9 1/2 years.</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Old Fracture of Right Hip. 7 yrs.</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Medical only.</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None.</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>4221</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None.</b>	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 **over 10 yrs** to **Sept. 1st, 1956**, that I last saw the deceased alive on **Aug. 31st, 1956**, and that death occurred at **7:30 A.M.** the causes and on the date stated above.

23a. SIGNATURE <b>Jno. B. Carlisle, M.D.</b>	(Degree or title)	23b. ADDRESS <b>Sedalia, Missouri.</b>	23c. DATE SIGNED <b>9-3-56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>9/3/1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>9-3-56</b>	REGISTRAR'S SIGNATURE <b>Laura Coon, Deputy</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. Weckert, Sedalia, Mo.</b>
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GILLESPIE FUNERAL HOME  
WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

251-

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 *Russell Q Mac*.....

Licensed Embalmer No. *480*.....

P. O. Address *Sedalia,*.....

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.