Health, & Welfare Public Service

. 300
1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004946
STATE FILE NUMBER

Registration District No. 83 Primary Registration District No. 4145 Registrar's No. 2

1. PLACE OF DEATH
a. COUNTY COOPER
b. CITY (If outside corporate limits, give ~~TOWNSHIP~~ only) ~~OR TOWN~~ PRAIRIE HOME MO — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) ~~HOSPITAL~~ OR ~~INSTITUTION~~ PRAIRIE HOME MO. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY COOPER
c. CITY ~~OR TOWN~~ PRAIRIE HOME MO. 0270 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS ~~(If outside, give location)~~ PRAIRIE HOME MO. — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last KUHN
4. DATE OF DEATH Month FEB. Day 21 Year 1959
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH Aug 21 - 1872
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months 6 Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER
10b. KIND OF BUSINESS OR INDUSTRY FARM
11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME CHRISTIAN KUHN
13b. MOTHER'S MAIDEN NAME LAURA SCHALLER
14. NAME OF HUSBAND ~~OR WIFE~~ MARGARET KUHN (DEAD)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. 495-40-4904
17. INFORMANT Herbert R. Kuhn Address Otterville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senility
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Not attended since and last saw him alive on
Death occurred at about 10:30 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M L DeMaeyer M D Coroner
22b. ADDRESS Boonville Mo
22c. DATE SIGNED 2/24/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 2/24/59
23c. NAME OF CEMETERY ~~OR CREMATORY~~ WALNUT GROVE
23d. LOCATION (City, town, or county) BOONVILLE (State) MO

24. FUNERAL DIRECTOR ADDRESS C. Albert Hornbeck Prairie Home Mo
25. DATE RECD. BY LOCAL REG. 2/24/59
26. REGISTRAR'S SIGNATURE Virginia T. Higgins

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 E. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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.