

DEB'D JUL 14 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22497
Do not use this space.

1. PLACE OF DEATH
(a) County Lafayette Registration District No. 460
(b) Township Davis Primary Registration District No. 4274
(c) City Higginsville (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Phillip Rahm
(a) Residence, No. Higginsville Mo. St. (If nonresident, give city or town and State) 1939
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cora Conklin Rahm

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug-12-1861

7. AGE YEARS 77 MONTHS 10 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

13. NAME Don't know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Proby Germany

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Proby Germany

17. INFORMANT (NAME) Mr. Phillip Rahm
(ADDRESS) Higginsville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Higginsville Mo. DATE June-24-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Loefer & Meinershagen

20. FILED July 1 1939 Tiffany Webb
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-22-1929

22. I HEREBY CERTIFY, that I attended deceased from April 15, 1939, to June 22, 1939
I last saw h. _____ alive on _____ 19____. Death is said to have occurred on the date stated above, at 12:05 PM.
The principal cause of death and related causes of importance were as follows:
Asphyxia & Strangulation Date of onset _____

Other contributory causes of importance: Carcinomas of lung, stomach, breast of tract & left testicle.

Name of operation None Date of _____
What test confirmed diagnosis? A.P. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) W. H. Conklin M. D.
Higginsville Mo. 413 (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

107

MISSOURI BRANCH 12

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7/12/39

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.....

..... Roy F. Wieggers Registered Apprentice No. 2883
working under my personal supervision.

Signed *Harper Mansur*
Licensed Embalmer No. 2883
P. O. Address Higginsville, 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH
 (a) County Lafayette Registration District No. 460
 (b) Township _____ Primary Registration District No. 4274 Registered No. _____
 (c) City Higginsville (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Phillip Rahm
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 10 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-22, 1957

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Asphyxiation & Starvation
Primary location not known
 Other contributory causes of importance: 40
Carcinoma of lung, stomach, & intest tract & left testicle

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____.
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. A. Braecklein, M. D.
 (Address) Higginsville Mo.

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK...THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

