

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.

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

32426
Do not use this space.

OCT 12 1939

1. PLACE OF DEATH **GREENE**
 (a) County **GREENE** Registration District No. **316**
 (b) Township **SPRINGFIELD** Primary Registration District No. **2001** Registered No. **721**
 (c) City **SPRINGFIELD** (d) Street No. **Frank Osteopathic Hospital** 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 **35** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Sophia Marie Boehm**
 (a) Residence, No. **742 N. Main** 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **O. H. Boehm**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 27 1874**

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
1 65	5	28	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 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) **Defiance Co. Ohio**

FATHER 13. NAME **Henry Polis**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

MOTHER 15. MAIDEN NAME **Mary Polis**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

17. INFORMANT (ADDRESS) **Otto H. Boehm 742 N. Main Springfield, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **East Lawn** DATE **Sept. 28 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Thieme Springfield, Mo.**

20. FILED **Sept 28 1939** **Chas A George M.D. Local Registrar**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **September 25 1939**

22. I HEREBY CERTIFY, that I attended deceased from **Aug 16 1939** to **Sept 24 1939**
 I last saw him alive on **Sept 24 1939**. Death is said to have occurred on the date stated above, at **12:30 p.m.**
 The principal cause of death and related causes of importance were as follows:
Inflamed gall bladder Date of onset

Other contributory causes of importance:
Pneumorrhagia
Peritonitis
 Name of operation **Removal of GB** Date of **9/15/39**
 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) **T. M. King D.D.**
 (Address) **Springfield, Mo.**

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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.....

Fred C. Thiem

Registered Apprentice No. *2899*

working under my personal supervision.

Signed *Fred C. Thiem*

Licensed Embalmer No. *2899*

P. O. Address *Springfield*

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.

X

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
DIVISION OF ANATOMY AND EMBALMING
CHICAGO, ILLINOIS

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32426
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township Springfield Primary Registration District No. 2005 Registered No. 721
 (c) City Springfield (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 Sophia Marie Bohm
 (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 F 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.
65 5 28

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) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 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 Nov 2 1939 Chas. George King Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-25-1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ 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:
Infected Gall Bladder
Gall Stones
pernicious anaphy.

Other contributory causes of importance: _____

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) G. M. King, M. D.
 (Address) Springfield Mo

SUPPLEMENTARY

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

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.

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