

STANDARD CERTIFICATE OF DEATH

State File No. 28326

Registration District No. 16

Primary Registration District No. 3014

Registrar's No. 221

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1418 E. Miller Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 75 years.  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Caroline Bohmann

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Herman Bohmann 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 17, 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>11</u>	<u>10</u>	hr. _____ min.

9. Birthplace \_\_\_\_\_ Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Franz Sindermann

13. Birthplace \_\_\_\_\_ Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_ Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura Latham

(b) Address 1418 E. Miller, J. C. Mo.

17. (a) Burial (b) Date thereof Aug. 29, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter Cem. J. C. Mo.

18. (a) Signature of funeral director [Signature]  
(b) Address Jefferson City, Mo.

19. (a) 8/29/40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole  
(c) City or town Jefferson City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1418 E. Miller Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 75 years. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27th.,  
year 1940 hour 9:05 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 8  
1940, 1940, to Aug 27, 1940:  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumonia

Due to \_\_\_\_\_

Due to Fractured left femur

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature Hean A. Taylor (M. D. or other) [Signature]  
Address Jefferson City Date signed 8-29-40

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

1949  
94

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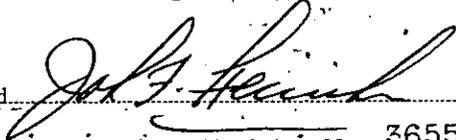
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 3655

P. O. Address. Jefferson City, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **283 2 6**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County **Jefferson**

(b) City or town **Jefferson**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) **Miss Caroline Bohman**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **8** day **27**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

Immediate cause of death **hypostatic pneumonia**

Duration \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<b>82</b>	<b>11</b>	<b>10</b>	_____ hr. _____ min.

Due to \_\_\_\_\_

Due to **fractured left femur**

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations: **1924**

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **July 6, 1940**

(c) Where did injury occur **Jefferson City, Cole, Mo.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **home**

While at work? **yes** (Specify type of place) \_\_\_\_\_  
(e) Means of injury **fell from chair**

23. Signature **Robert A. Taylor** (M. D. or other **M.D.**)  
Address **Jefferson City** Date signed **10-8-40**

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

