

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

PLACE OF DEATH
County Moniteau
Township _____
or
Village _____
or
City Tipton (NO. _____ St.: _____ Ward)

Registration District No. 575 File No. 9990
Primary Registration District No. 4339 Registered No. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME John Hohimer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>September 2, 1854</u> (Month) (Day) (Year)		
AGE <u>57 yrs. 6 mos. 17 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>labour</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>3-07</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>		
PARENTS	NAME OF FATHER <u>Joseph Hohimer</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>	
	MAIDEN NAME OF MOTHER <u>Polly McCubbers</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 19, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dead on Death, 1913, that I last saw him alive on Mar-18th, 1913, and that death occurred, on the date stated above, at 7 A. m. The CAUSE OF DEATH* was as follows:
Cerebral Embolism

(Duration) Several mos. ds.
Contributory Subocular Disease
(Signed) Wm. M. Marsh M. D.
Mar-18th, 1913 (Address) Tipton Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted
If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL
Tipton, Mo

DATE OF BURIAL
March 20 1913

UNDERTAKER
L. Patterson & Son

ADDRESS
Tipton, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jodie Hohimer
(ADDRESS) Sedalia Mo.

Filed Mar 19, 1913 Frank D. Welbiss
REGISTRAR

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.

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

(If death hospital, give its name and street address)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
 SINGLE _____
 MARRIED _____
 WIDOWED _____
 OR DIVORCED _____
 (If wife the word)

DATE OF BIRTH _____ (Month) _____, 191____, at _____ (Day) _____, 1____ (Year)
 IF LESS than 1 day, _____ hrs. or _____ min.?

AGE _____ yrs. _____ mos. _____ ds.

OCCUPATION _____
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____
 (City or town, State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

**MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTIC
 CERTIFICATE OF DEATH**

**Revised United States Standard Certificate
 of Death**

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____, at _____ (Day) _____, 1____ (Year)

I HEREBY CERTIFY, that I attended decedent _____, 191____, to _____, that I last saw him _____ alive on _____ and that death occurred, on the date stated above, a _____
 The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos.

(Signed) _____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TI REGENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ In the _____
 Where was disease contracted if not at place of death? _____ Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL OR REMOVAL _____

UNDERTAKER _____ ADDRESS _____