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.

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

PLACE OF DEATH

County Monteau

Township ____ or Village ____ or City Tipton

Registration District No. 575 Primary Registration District No. 4339

File No. 9990 Registered No. 44

(NO. ____ St.: ____ Ward) [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	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	married

DATE OF BIRTH September (Month) 2 (Day) 1854 (Year)

AGE 57 yrs. 6 mos. 17 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 3-07

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

PARENTS
NAME OF FATHER Joseph Hohimer
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Polly McCubbens
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jodie Hohimer

(ADDRESS) Sedalia Mo

Filed Mar 19 1913. Frank D Wilson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Sudden Death, to ____, 191__, that I last saw him alive on Mar 18th, 1913, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism (Duration) Suddenly mos. ds.

Contributory (Secondary) Pulmonary Oedema (Duration) 10 hrs. mos. ds.

(Signed) Jno M Marsh M. D.

Mar 19th 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	DATE OF BURIAL
Tipton, Mo	March 20 1913
UNDERTAKER	ADDRESS
L. Patterson & Son	Tipton, Mo

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

City _____(NO._____, _____St.;_____Ward)

[If death hospital give its l of street a

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day, ____hrs. or ____min.?

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)

PARENTS

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____
(Month) (Da

I HEREBY CERTIFY, that I attended dec

_____, 191___, to_____

that I last saw h____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 Violen (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TI RECENT RESIDENTS)

At place of death____yrs.____mos.____ds. In the State____yrs.____m

Where was disease contracted If not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BI
UNDERTAKER	ADDRESS