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.

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

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

PLACE OF DEATH

County Shelby

Township Lentner

or

Village

or

City (NO. St.; Ward)

Registration District No. ~~60~~ 832

Primary Registration District No. 6095

File No. 28231

Registered No. 2

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

FULL NAME not named,

## PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: Sept (Month) 7 (Day), 1914 (Year)

AGE: yrs. mos. 1 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): Lentner no

PARENTS

NAME OF FATHER: Wm R. Gerlich

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

MAIDEN NAME OF MOTHER: Catherine Nothnagel

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. R. Gerlich.

(ADDRESS) Lentner

Filed 8-10, 1914 A. M. Wood REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 8 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from —, 191, to —, 191, that I last saw h alive on —, 191, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Unknown. died suddenly, no Physician got there

158 (Duration) yrs. 188 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) A. M. Wood M. D.

, 191 (Address) Lentner

*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: Mt. Hope

DATE OF BURIAL: 8-9-, 1914

UNDERTAKER: Relatives

ADDRESS

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

**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 occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

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

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (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) ..... (Day), *191*..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) ..... M. D.

....., 191..... (Address) .....

*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 ....., 191..... |
|---|---|
| UNDERTAKER | ADDRESS |

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.