MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

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

PLACE OF DEATH

County: Cape Girardeau

Township or Village or City: Cape Girardeau (NO. ____ West Broadway St.; 2 Ward)

Registration District No. 125 — File No. 27005

Primary Registration District No. 3009 — Registered No. 1231

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

FULL NAME: Henry Jung

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male — COLOR OR RACE: White — SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: May (Month) 10 (Day), 1885 (Year)

AGE: 30 yrs. 3 mos. 25 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
- NAME OF FATHER: Henry Jung
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
- MAIDEN NAME OF MOTHER: unknown
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Hy Jung

(ADDRESS): Cape Gir Mo

Filed Sept 6, 1915 — P. W. Friesell, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: September (Month) 4 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 22, 1915, to Sept 4, 1915, that I last saw him alive on Sept 4, 1915, and that death occurred, on the date stated above, at 2:50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 23A

(Duration) about 1 yrs. 0 mos. 0 ds.

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

(Signed) W. A. Schoen M. D.

Sept 4, 1915 (Address) Cape Girardeau 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: Fairmount Cemetery — DATE OF BURIAL: Sept 6, 1915

UNDERTAKER: Southeast Mo Und Co — ADDRESS: Cape Gir Mo

MARGIN RESERVED FOR BINDING

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.....

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

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