

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 Camden
Township St. Clair
or
Village
or
City

Registration District No. 118
Primary Registration District No. 169

File No. 29980
Registered No. 2

St. Ward

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

FULL NAME Walter Cahel

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Dec. 18, 1891
(Month) (Day) (Year)

AGE 23 8 3 If LESS than
yrs. mos. ds. 1 day, hrs. or min.?

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

BIRTHPLACE
(City or town, State or foreign country) Camden Co. Mo.

PARENTS
NAME OF FATHER John W. Cahel, mo.
BIRTHPLACE OF FATHER Camden County
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER don't know
BIRTHPLACE OF MOTHER don't know
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Bishop, mo.

(ADDRESS) Osage Bluffs, Mo.

Filed Oct 14, 1914 J. M. Tate

REGISTRAR

V MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from as one, 191, to of the, 191, that I first saw him on Aug 22, 1914, and that death occurred, on the date stated above, at 5.0 m.

THE CAUSE OF DEATH* was as follows: He was shot to death by John Allen at a picnic atrontown, Camden Co. Mo. Was a farmer, was killed by a shot as a picnic in the

Contributory (SECONDARY) injury yrs. mos. ds.

(Signed) J. B. Bishop M. D.
Oct 14, 1914 (Address) Osage Bluffs, 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

Franklin Cemetery

Aug 22, 1914

UNDERTAKER

ADDRESS

John White

Osage Bluffs, Mo.

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

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

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(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) _____ (Year) _____

AGE _____ yrs. _____ mos. _____ ds. _____

IF LESS than 1 day, _____ hrs. _____ 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)

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) _____ (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) _____ 191 _____ (Address) _____ M. D. _____

* 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. 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 _____ 191 _____

UNDERTAKER _____ ADDRESS _____