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.

MARGIN RESERVED FOR BINDING

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

PLACE OF DEATH

County: Pettis

Township ..... or Village ..... or City: Sedalia (NO. 1931 E 7 St.; ..... Ward)

Registration District No. 668 File No. 25379

Primary Registration District No. 3032 Registered No. 208

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

FULL NAME Marcus Mehl

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~ (~~Write the word~~): S

DATE OF BIRTH: Mar (Month) 11 (Day), 1911 (Year)

AGE: 5 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 1222

BIRTHPLACE (City or town, State or foreign country): Sedalia Mo

PARENTS

NAME OF FATHER: Frank Mehl

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

MAIDEN NAME OF MOTHER: Anna Volmer

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Mehl

(ADDRESS) Sedalia Mo

Filed July 25 1916 H. B. Pons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 24th (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July 20th, 1916, to July 24, 1916, that I last saw him alive on July 24, 1916, and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows: Intussusception of bowel, lower part of ileum

(Duration) 109 yrs. 7 mos. 7 ds.

Contributory (SECONDARY) Cardiac failure

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) C. L. Frasier M. D.

July 25, 1916 (Address) Sedalia

*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: Sedalia Mo

DATE OF BURIAL: July 27 1916

UNDERTAKER: McLaughlin

ADDRESS: Bro

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), *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

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

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