

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.

PLACE OF DEATH

County Pettis

Township _____

or

Village Smithton

or

City _____ (NO. _____ St. _____ Ward _____)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 669File No. 2499-APrimary Registration District No. 4406-892Registered No. 5

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

FULL NAME

Elizah Hotsenpiller

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
--------------------	-------------------------------	--

DATE OF BIRTH

Aug 19, 1843
(Month) (Day) (Year)

AGE

71 yrs. 5 mos. 11 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) Strasburg Va.

PARENTS

NAME OF FATHER

Jacob Hotsenpiller

BIRTHPLACE OF FATHER

(City or town, State or foreign country) America

MAIDEN NAME OF MOTHER

Don't know

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva Hotsenpiller(ADDRESS) South Bend, Ind.Filed Feb 1 1917, S. M. Parnell

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan 30, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug., 1912, to Jan 30, 1917, that I last saw him alive on Jan 30, 1917, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

Contributory

(SECONDARY)

(Duration) 5 yrs. _____ mos. _____ ds.

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

(Signed)

S. M. Parnell M. D.
Feb 1, 1917 (Address) Smithton 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

Smithton Cemetery

DATE OF BURIAL

Feb 1, 1917

UNDERTAKER

Neumejer

ADDRESS

Smithton Mo

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. 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)NAME OF
FATHERBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

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

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.

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) 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