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 17693

PLACE OF DEATH

County Nodaway
Township ~~Atchison~~
or
Village Clearmont
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 619 File No. 5821
Primary Registration District No. 4370 Registered No. 619

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

FULL NAME August Fredick Stelter

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: March (Month) 12 (Day), 1843 (Year)

AGE: 76 yrs. 2 mos. 19 ds. If LESS than 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): Libby Germany

PARENTS
NAME OF FATHER: Fredick Stelter
BIRTHPLACE OF FATHER (City or town, State or foreign country): Libby Germany
MAIDEN NAME OF MOTHER: Wilhelmina Miers
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Libby Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Stelter
(ADDRESS) Clearmont Mo

Filed May 30, 1919 T G Rogers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 27 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from May 27, 1919, to May 27, 1919, that I last saw him alive on May 27, 1919, and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease
131 / 20
(Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) H. S. Dowell M. D.
5/28, 1919 (Address) Clearmont 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: Maryville Mo
DATE OF BURIAL: May 31, 1919
UNDERTAKER: John Price
ADDRESS: Maryville Mo

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 ..... (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