

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

11400

1. PLACE OF DEATH

County DeWitt Registration District No. 877 File No. _____
 Township DeWitt Primary Registration District No. 45-30 Registered No. 8
 City Schell City (No. _____) St. _____ Ward _____

2. FULL NAME

Eliged Dr. Childers
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Thora B. Childers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 2 / 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 67 5 17

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER J. W. Childers
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mattson (STATE OR COUNTRY) Illinois
 12. MAIDEN NAME OF MOTHER Taylor
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mattson (STATE OR COUNTRY) Ill

14. INFORMANT Flored Childers (Address) Schell City Mo

15. FILED 4/4 1922 H. C. Jarvis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 19 1922

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1922, to Mar 19 1922, and that I last saw him alive on Mar 18 1922, and that death occurred, on the date stated above, at 8:30 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertrophy of Heart and Hypertrocardium

950 about (duration) 2 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY)
900 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Dr. A. C. Burk, M. D.
 , 19 (Address) Schell City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Missouri Lawn DATE OF BURIAL Mar 22 1922

20. UNDERTAKER Missouri Lawn ADDRESS Schell City 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.

