

16 1927

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

Do not use this space.

23954

1. PLACE OF DEATH

County Bole
Township Liberty
City (No. _____) _____

Registration District No. 215
Primary Registration District No. 5295

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

John Herman Cortorient
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

Catherine

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6-1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 2 25

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) Boas, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Jno. Cortorient

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Belgium
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Koling

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Mrs. J. N. Cortorient
(Address) Schaffers, Mo.

15. FILED 8-2-27 L. F. Cruise REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug - 1 - 1927

17. I HEREBY CERTIFY That I attended deceased from 15 1927 to 8-1-27 1927 that I last saw him alive on 8-8-27 and that death occurred, on the date stated above, at 7:30 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

apoplexy

CONTRIBUTORY (SECONDARY)

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? Symptomatic
(Signed) L. F. Cruise, M. D.
8-2, 1927 (Address) Ozage 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Boas, Mo. DATE OF BURIAL 8-3-1927

20. UNDERTAKER Chas. P. Heinrichs ADDRESS 86. Mo.

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.

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