

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

Do not use this space.

33187

1. PLACE OF DEATH

County Garcasade
Township Whind-creek
City (Name)

Registration District No. 991
Primary Registration District No. 5419

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

2. FULL NAME

Albert Fritz Czechoslovak

(a) Residence. No. _____ Ward. _____
(Usual place of abode)

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. (If nonresident give city or town and State)

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 Husband of Minnie Kuchler

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 2 15

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Woollam
(STATE OR COUNTRY) Black Mo.

10. NAME OF FATHER Chas Czechoslovak

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

12. MAIDEN NAME OF MOTHER Albertine Kuchler

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

14. INFORMANT Mrs Minnie Czechoslovak
(Address) Rt 2, Ottumwa Mo.

15. FILED 12/1/27 J. L. Price
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-22 1927

17. I HEREBY CERTIFY, That I attended deceased from 11-15, 1927, to 11-22, 1927, that I last saw him alive on 11-23, 1927, and that death occurred, on the date stated above, at 9:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

100 Pneumonia
8763
015
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Cerebral Nerve Paralysis
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Dr. Cedar Mellin, M. D.

11-22-1927 (Address) Ottumwa 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 DATE OF BURIAL

St John Evangelical cemetery 11-28 1927

20. UNDERTAKER ADDRESS

Heuman Koch Ottumwa 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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[illegible]

J. H. Ford

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Gasconade
Township Third Creek
City (No.)

Registration District No. 991
Primary Registration District No. 3419

File No. 33187
Registered No.
St. Ward

2. FULL NAME

Albert Fritz Gresham

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 12/27 1927

REGISTRAR J. C. Price

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-22 1927

17. I HEREBY CERTIFY, That I attended deceased from to , 1927
(that I last saw h. alive on , 1927, and that death occurred, on the date stated above, at m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
(duration) yrs. mos. ds. X
CONTRIBUTORY Chronic nerve trouble
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D.
19 (Address)

*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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

THIS IS A PERMANENT RECORD

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRATION FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBE

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