

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

Do not use this space.

✓ 34098

**1. PLACE OF DEATH**

County Marion Registration District No. 547  
 Township Mason Primary Registration District No. 2014  
 City Hannibal (No. Levering Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 317

**2. FULL NAME** Fred Bucholtz

(a) Residence No. New London, Mo. St. \_\_\_\_\_ Ward. New London Mo.  
 (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) Single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
41

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Forman Gravel Pit  
 (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 \_\_\_\_\_

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 W. C. Ramsey (Address) Hannibal Mo

15. FILED Nov 26 1927 W. C. Stoll REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25 @ 27

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at 1:00 A.M. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septhermia  
205G  
36

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

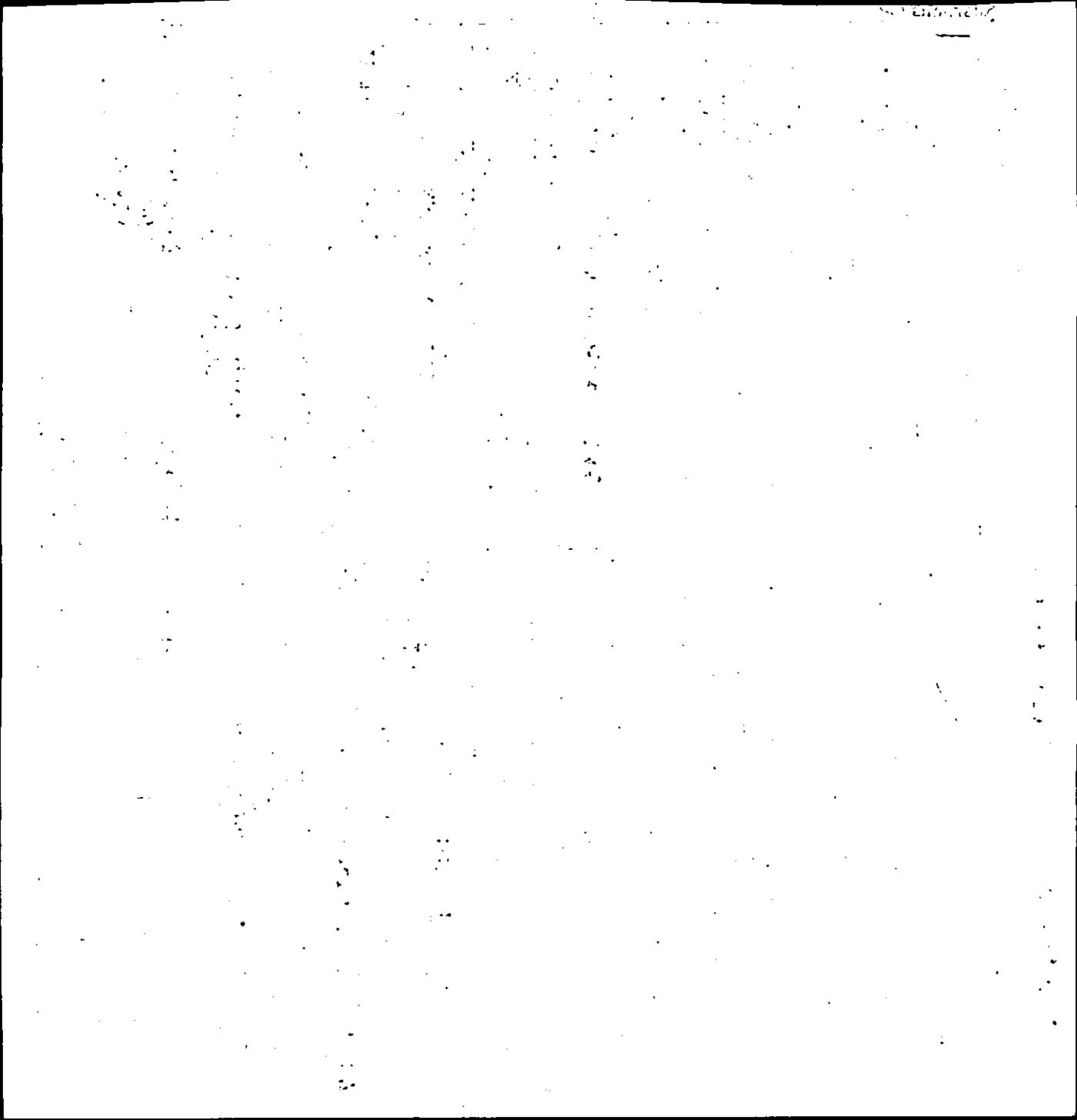
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH. \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? yes Partial  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Chas. R. South coroner  
Misses me

\*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 Bradford Ohio DATE OF BURIAL 11/26 1927

20. UNDERTAKER Wm. M. Smith ADDRESS Hannibal, Mo.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Marion Registration District No. 547 File No. ....  
 Township Mason Primary Registration District No. 3029 Registered No. 312  
 City ..... (No. ....) St. .... Ward .....

**2. FULL NAME** Fred Bucholtz

(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. 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) S

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

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

7. AGE about 41 YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) yrs. mos. ds.  
 (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 Nov 26, 19 27 Col Strode

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 19 27

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septicemia  
by caught in Bell's Creek  
 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) 187  
 (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) Chas. R. Scott Corcoran, M.D.  
 , 19 Nov 25 19 27  
 (Address) Marion Co 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

**20. UNDERTAKER**

ADDRESS

19

Every item of information should be carefully 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. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. REG

SUPPLEMENTARY

5-34098