

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

DO NOT USE THIS SPACE
36375

1. PLACE OF DEATH

County Cooper
Township Palestine
City (Name) _____

Registration District No. 219
Primary Registration District No. 5301

File No. 2A
Registered No. 29
St. _____ Ward _____

2. FULL NAME James Willard Korte

(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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 12th 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Boonville
(STATE OR COUNTRY) Cooper Co.

10. NAME OF FATHER H. E. Korte

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

12. MAIDEN NAME OF MOTHER Mary Broyles

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

14. INFORMANT H. E. Korte
(Address) Boonville, R.R. #4

15. FILED 12/28 1927 Hullis Papp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 27th 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Natural Causes
"Pneumonia" P I

10 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

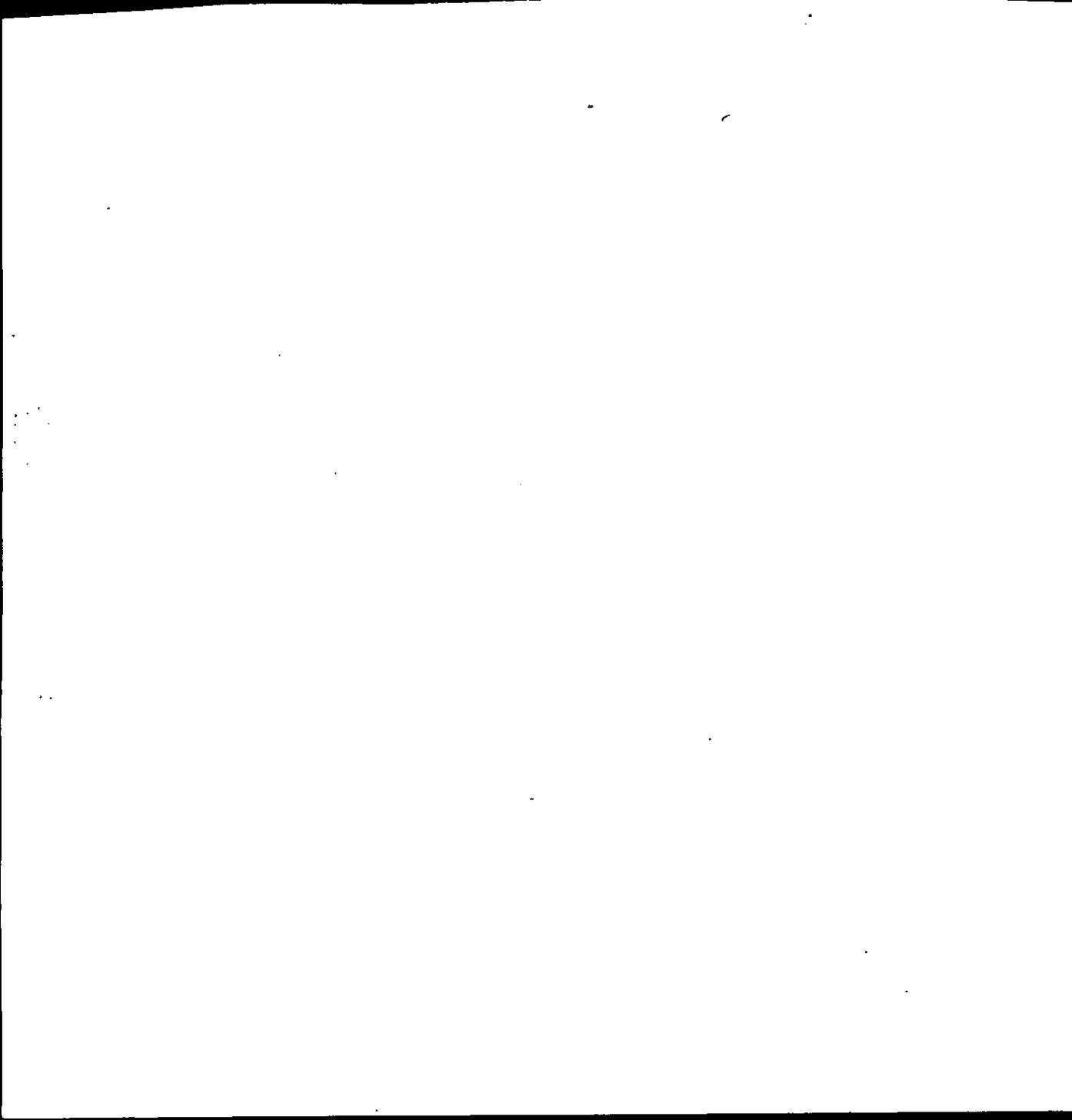
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS. (Signed) Herman Schwitzky
, 19____ (Address) Boonville 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 Boonville City Cem. DATE OF BURIAL Dec 27th 1927

20. UNDERTAKER Schwitzky Meister ADDRESS Boonville



**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 Cooper
Township Palatine
City (No.)

Registration District No. 219
Primary Registration District No. 5301

File No.
Registered No. 23
St. Ward)

2. FULL NAME

James Willard Forte
(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)

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. 1/20 19 28 Hattie Paxton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that (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:

Natural Causes
"Pneumonia"
Bronchial
7 days (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 100% (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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-36376