

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

Do not use this space.

1. PLACE OF DEATH

County Lawrence
Township Yegon
City William Miller

Registration District No. 467
Primary Registration District No. 155B
4282

File No. 5496
Registered No. 2
St. _____ Ward _____

2. FULL NAME

William Robert Stahl

(a) Residence No. _____ St. _____ 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.

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

Laura Stahl

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

11

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

71

11

2

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)

(STATE OR COUNTRY)

Lawrence Co, Mo

10. NAME OF FATHER

B. H. Stahl

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

12. MAIDEN NAME OF MOTHER

Sarah McShee

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14.

INFORMANT
(Address)

Zella Stahl
Miller, Mo

15.

FILED

2-10 1928
W. S. Emery
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

2-2 1928

17.

I HEREBY CERTIFY, That I attended deceased from 12-7, 1928, to 2-2, 1928
that I last saw him alive on 2-2, 1928, and that death occurred, on the date stated above, at 5-0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

in over dose of carb. acid
1750

CONTRIBUTORY (SECONDARY)

in few mts of cystitis prior to his death

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? 7/1 DATE OF.....

WAS THERE AN AUTOPSY? 7/1

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

W. S. Emery, M. D.

, 19 (Address) Miller 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. Horremedus

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Stahl Cemetery

2-4 1928

20. UNDERTAKER

ADDRESS

J. W. Mornie

Miller Mo.

MAR 19 1928

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.

PHYSICIAN
H. J. ...

CAUSE OF DEATH
The cause of death should be carefully ascertained and reported in the terms, so that it may be

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lawrence Registration District No. 469 File No. _____
 Township _____ Primary Registration District No. 4282 Registered No. _____
 City Miller (No. _____) St. _____ Ward _____

2. FULL NAME William Robert Stahl

(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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-2-1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>91</u>	<u>11</u>	<u>2</u>		

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 3-7-28 W. S. Boney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-2-1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

An acute dose of Carbo acid 7 to 8 days
 _____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) a few weeks of cystitis
miror of his death (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? 1999 YES _____ NO _____

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 _____

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

SUPPLEMENTARY

