

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

Do not use this space.

14009

1928

1. PLACE OF DEATH

County Macon Registration District No. 533
 Township Macon Primary Registration District No. 3027
 City Macon (No.) St. Ward)

File No.
 Registered No. 48

2. FULL NAME Frank M. Pether

(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 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 Abbie Pether

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 21, 1845

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
82 8 4

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

9. BIRTHPLACE (CITY OR TOWN) Meigs Co.
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Peter Pether

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

12. MAIDEN NAME OF MOTHER doubt know

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

14. INFORMANT Mrs. Abbie Pether
 (Address) Macon, Mo.

15. FILED 1/8 28 Mrs. Luke Finkler
 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/25 1928

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1928, to April 24, 1928, that I last saw him alive on April 23, 1928, and that death occurred, on the date stated above, at 6:30 a.m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial Infarction
off day. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) renal colic
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAICTED B
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) [Signature], M. D.
 , 19 (Address) Macon, 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 Ten Mile Baptist Cem. **DATE OF BURIAL** 4/26 1928

20. UNDERTAKER Stephens & Gooding **ADDRESS** Macon, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

M. R.—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.

RECEIVED FOR BINDING

