

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

Do not use this space.

20216

1. PLACE OF DEATH

County Coole

Registration District No. 213

Township Jefferson

Primary Registration District No. 3014

City Jefferson (No. St. Marys Nov.)

File No. _____

Registered No. 145

St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____

(Usual place of abode)

Freeburg Mo.

(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)

Single

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

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

Dec. 23-1896

7. AGE

YEARS

MONTHS

DAYS

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

31

5

20

8. OCCUPATION OF DECEASED

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

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)

Westphalia Mo.

10. NAME OF FATHER

Anton Tillmann

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

Loosereck Mo.

12. MAIDEN NAME OF MOTHER

Pheresa Maynes

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

Poas Mo.

14.

INFORMANT (Address)

Anton Tillmann Freeburg, Mo.

15.

FILED

6-21-28 S. O. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

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

June 12 1928

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chole Cystitis 1278

124/10

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Hiccoughs

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S. O. Bedford M. D.

, 19 (Address) Jefferson City 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

Freeburg Mo.

DATE OF BURIAL

6-14 1928

20. UNDERTAKER

C. P. Heirich

ADDRESS

J. B. 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.

