

Filed *Schroer*
 22 1928 *Producers Rev.*

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

Do not use this space.

23236

1. PLACE OF DEATH

County *Cape Girardeau* Registration District No. *129*
 Township *Shannon* Primary Registration District No. *5180*
 City *.....* (No.) St. Ward)

File No. *3*
 Registered No. *19*

2. FULL NAME *Elam S. Timpler*

(a) Residence. No. *Fruitland Mo.* 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. 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) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 13. - 1841*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
87 6 16

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) *Fruitland Mo.*

10. NAME OF FATHER *Orin S. Timpler*

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

12. MAIDEN NAME OF MOTHER *M. Boone*

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

14. INFORMANT *A. H. Timpler* (Address) *Greenville Mo.*

15. *July 30 1928* *F. J. Schroer* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 29th 1928*

17. I HEREBY CERTIFY That I attended deceased from *July 28* to *July 29* 1928. I last saw him alive on *July 28* 1928, and that death occurred, on the date stated above, at *3:35 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy

82A 7401
 CONTRIBUTORY (SECONDARY) *.....*
 18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH *.....*

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF *.....*
 WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Symptomatic*
 (Signed) *D. H. Liebur* M. D.
7-29-1928 (Address) *Jackson 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 *Pleasant Hill Cem* DATE OF BURIAL *July 30 1928*

20. UNDERTAKER *Walther Wad. Co Cape Gir 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.

