AUG 29 1928

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

Do not use this space.

1. PLACE OF DEATH
County: Scott
Township: Sylvania
City: (No. ..... St. ..... Ward)
Registration District No. 820
Primary Registration District No. 4496
File No. 26119
Registered No. 764

2. FULL NAME: John F Elfrank
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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.

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): 10/15/60

7. AGE: 67 YEARS, 9 MONTHS, 4 DAYS. If LESS than 1 day, ... hrs. or ..... min.

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): Mo

PARENTS
10. NAME OF FATHER: Herman Elfrank
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ger.
12. MAIDEN NAME OF MOTHER: Dont Kn
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Kn

14. INFORMANT: Jim Elfrank
(Address): Oran Mo

15. FILED 8-9, 1928 G J Wickman REGISTRAR
GBH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7/19 1928

17. I HEREBY CERTIFY, That I attended deceased from 7/15, 1928, to 7/19, 1928, that I last saw him alive on 7/18, 1928, and that death occurred, on the date stated above, at 11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Hepatitis
1 2 5 D 1 2 4 B, (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? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) J A Clinn, M. D
, 19 (Address) Oran 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: Catholic Cemetery
DATE OF BURIAL: 7/20 1928

20. UNDERTAKER: Alois Anger
ADDRESS: Mo Leopold

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.

PERMANENT RECORD