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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**  
 County St Charles Registration District No. 957 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3039 Registered No. 136  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Alphonse Pascher  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** S  
(write the word)

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

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

<b>7. AGE</b>	<b>YEARS</b>	<b>MONTHS</b>	<b>DAYS</b>	<b>IF LESS than 1 day, hrs. or min.</b>

**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 \_\_\_\_\_

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Sept 9 1928  
**17.** I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Gun shot wound from a shot gun in the hands of Frank W. Schaefer  
by court  
 CONTRIBUTORY \_\_\_\_\_ (duration) yrs. mos. da.  
 SECONDARY probable accident or homicide (duration) yrs. mos. da.

**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) \_\_\_\_\_

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

**14. INFORMANT** \_\_\_\_\_  
 (Address) \_\_\_\_\_  
 FILED 9/12 28 By G. Bloebaum  
 REGISTRAR

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** \_\_\_\_\_ **DATE OF BURIAL** \_\_\_\_\_ 19\_\_\_\_

**20. UNDERTAKER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

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

**SUPPLEMENTARY**

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S-31423