

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

Do not use this space.

35311

NOV 21 1928

K. 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.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 746
 City Springfield (No. Baptist Hospital) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Houston 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 m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12-1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 | 3 | 12 | _____

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) Germany

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Marie Kouba
Houston St. _____

15. FILED 10-24-28 19 06. Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-24-28

17. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1928, to Oct 28, 1928
 that I last saw him alive on Oct 28, 1928, and that death occurred, on the date stated above, at 11:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
A
Appendicitis - acute
traumagenous with
abscess, jaundice
 (duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY (SECONDARY) 11/10
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

1 DID AN OPERATION PRECEDE DEATH? no DATE OF Oct 23

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. S. DeCarman, M. D.
 , 19 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL CREMATION, OR REMOVAL DATE OF BURIAL
Houston Mo. 10-26-28

20. UNDERTAKER ADDRESS
Alva Schreyer 534 S. Main

