

Dr. Bedford

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

Do not use this space.

36436

1. PLACE OF DEATH

County.....Cole.....Registration District No.....213.....

File No.....

Township.....

Primary Registration District No.....3014.....Registered No.....267.....City.....Jefferson..... (No.....).....

St..... Ward.....

2. FULL NAME Adam Flessa

(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.

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) November 14-1863

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

641128

8. OCCUPATION OF DECEASED

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

Stone Mason

(b) General nature of industry, business, or establishment in which employed, (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cole County Mo

(STATE OR COUNTRY)

10. NAME OF FATHER

Peter Flessa

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany12. MAIDEN NAME OF MOTHER Lucina Hahn(STATE OR COUNTRY) Germany

PARENTS

14.

INFORMANT Herman Flessa(Address) Jefferson City, Missouri

15.

FILED 11-13-28 Dr. Bedford

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 12 19 28

17.

I HEREBY CERTIFY, That I attended deceased from Oct 311928, to Nov 12, 1928that I last saw him alive on Nov 12, 1928, and that death occurred, on the date stated above, at 2:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tetanus
Injury to head

CONTRIBUTORY (SECONDARY)

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) Surgeon, M. D.Nov 12, 1928 (Address) Jefferson City

*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

Lutheran Cemetery

DATE OF BURIAL

11/14 19 28

20. UNDERTAKER

WILLIAM GORDON UNDERTAKING CO.

ADDRESS

Jefferson City

**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 Cole Registration District No. 213 File No. _____
 Township _____ Primary Registration District No. 3014 Registered No. 268
 City Jefferson (No. _____) St. _____ Ward _____

2. FULL NAME Adam Flessa
 (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

3. SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
7. AGE YEARS MONTHS DAYS **IF LESS than 1 day,** hrs. or min.

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 _____

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) _____

14. INFORMANT _____
 (Address) _____

15. FILED 11-13-28 Sured Jork
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 12 - 1928
17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

status
injury to head
from fall on
concrete
on

CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. da.

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) _____

*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 _____ **DATE OF BURIAL** _____, 19____

20. UNDERTAKER _____ **ADDRESS** _____

SUPPLEMENTARY

N. B. - Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH as fully as possible. Exact statement of OCCUPATION is very important. REGISTRY FEE - FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-36426