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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.

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

Do not use this space.

1605

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. 119)

Registration District No. 399
Primary Registration District No. 1002
City Bellevue

File No. 196
Registered No. 196
St. Ward

2. FULL NAME

(a) Residence No. 119 1. Bellevue 10 Ward.

(Usual place of abode)
Length of residence in city or town where death occurred 29 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

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**Lena Schurig**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**Sept 18, 1892**7. AGE**76

YEARS

3

MONTHS

26

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Brewer

(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)

Switzerland**10. NAME OF FATHER**No record**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

No record**12. MAIDEN NAME OF MOTHER**No record**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

No record**14.**INFORMANT
(Address)Barbara Schurig
1729 Hawthorn**15.**

FILED

1-14-29
M. M. Crave
Asst REGISTRAR**MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)**Jan 14 1929**17.**

I HEREBY CERTIFY, That I attended deceased from

11/10, 1929, to 1-14, 1929.that I last saw him alive on 11/13, 1929, and that death occurred, on the date stated above, at 8 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OFWAS THERE AN AUTOPSY? NoWHAT TEST CONFIRMED DIAGNOSIS? Histology + Physical Findings(Signed) J. H. [Signature], M. D.1/14, 1929 (Address) 2822 So. [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**ElmwoodJan 16, 1929
ADDRESS**20. UNDERTAKER**Mrs. FosterK. C. [Signature]

THIS IS A PERMANENT RECORD

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31

~~H.P. 6976~~

val. 5348
738

2-4-

2855 Ernest L. H. J.