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MAR 21 1929

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

Do not use this space.

5416

1. PLACE OF DEATH Benton County
Township Williams
City Cole Camp (No. ..... St. ..... Ward)

Registration District No. 59
Primary Registration District No. 4034

File No. .....
Registered No. 2

2. FULL NAME Benhard Cordes

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Katie Cordes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-10-1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired 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) Missouri

PARENTS

10. NAME OF FATHER Jacob Cordes

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Mrs Katie Cordes
(Address) Cole Camp Mo

15. FILED 3-1-1929 Harry Bay REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-1-1928, to 2-4-1929 that I last saw him alive on 2-4-1929, and that death occurred, on the date stated above, at 12:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82A
97 (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) 5 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH? At home
DID AN OPERATION PRECEDE DEATH? No DATE OF X
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) T. H. Weser, M. D
2-5-1929 (Address) Cole Camp 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 Cheese Creek
DATE OF BURIAL 2-6 1929

20. UNDERTAKER E. L. Eickhoff
ADDRESS Cole Camp

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.

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