

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

Do not use this space.

6060

1. PLACE OF DEATH

County Franklin
Township Union
City Union, Mo

Registration District No. 296
Primary Registration District No. 4180

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-16-1860

7. AGE YEARS 69 MONTHS 7 DAYS 7 IF LESS than 1 day, _____ hrs. _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(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) Austra

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 Mrs. Wm. Dress (Address) Suph. County Home

15. FILED Feb 22 1929 E. A. Steubner REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1924, to Feb 27 1929, that I last saw h. my alive on Feb 21 1929, and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Permit of property
1/4 of 1/4
Admission released
(duration) _____ yrs. _____ mos. 17 da.

CONTRIBUTORY (SECONDARY) _____ (duration) 5 yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physic
(Signed) E. A. Steubner, M. D.

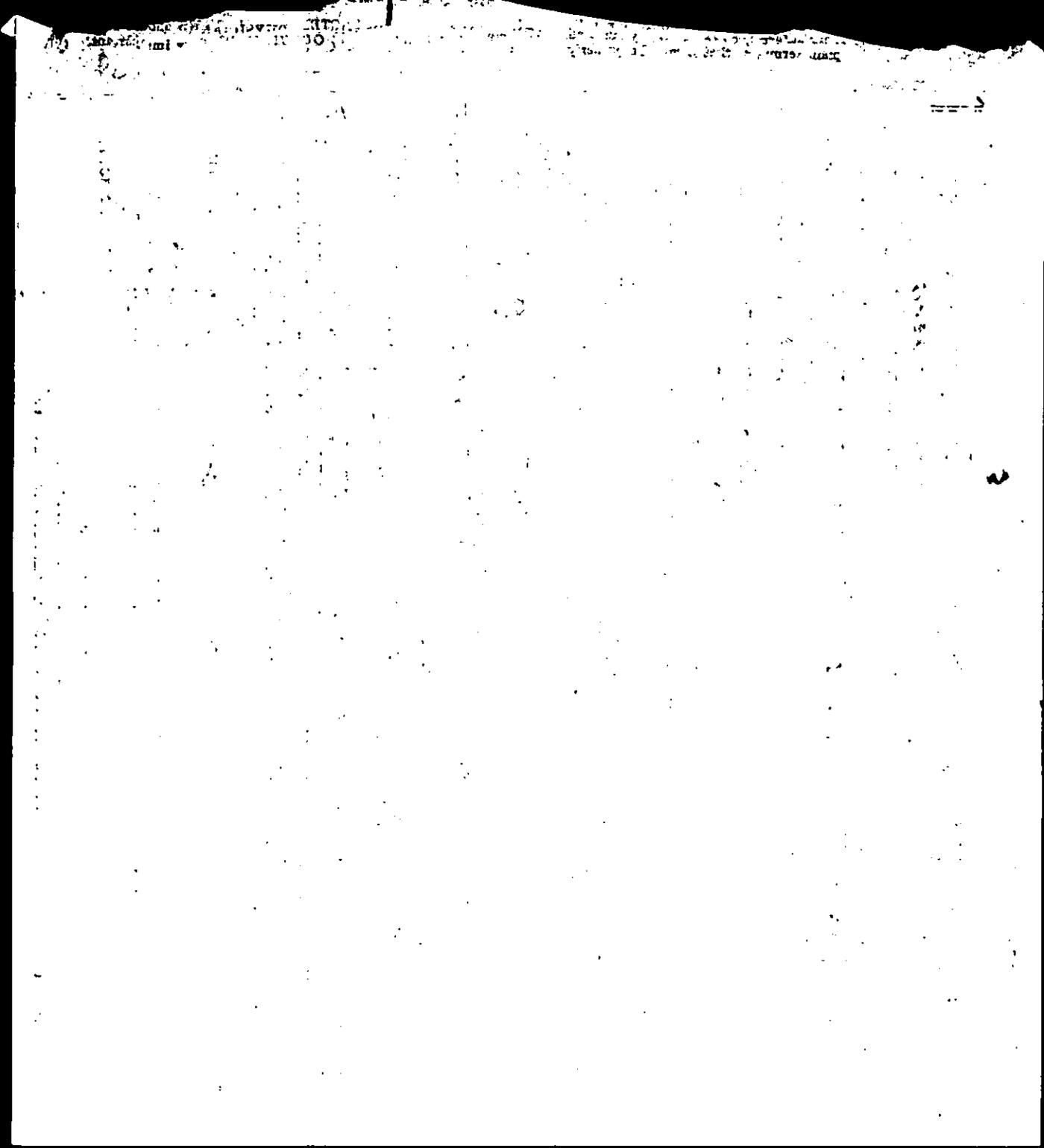
(Address) Union Mo

*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 Catholic Cem Washington Mo DATE OF BURIAL Feb 23 1929

20. UNDERTAKER Maibury & Vitt Washington Mo ADDRESS _____

MAR 21 1929
 68-3-6
 31
 31
 PHYSICIANS should be stated EXACTLY. PHYSICIAN'S SIGNATURE. AGE should be stated EXACTLY. AGE should be properly classified. Exact statement of OCCUPATION is very important. Main terms, so that it may be properly classified.



**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 Franklin
Township Union
City..... (No.....).....

Registration District No. 296
Primary Registration District No. 4180

File No.....
Registered No.....
St..... Ward.....

2. FULL NAME

John Scharke

(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 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) 10/16-1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 3 6

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 2/22 1929 E. A. Stuebner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 22 1929 19

17. I HEREBY CERTIFY That I attended deceased from.....
19..... to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)....., 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

20. UNDERTAKER

ADDRESS

19

SUPPLEMENTARY

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS and U. S. STATE CAUSE OF DEATH; informants should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. THIS IS A PHARMACY RECORD. THIS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

STATE OF CALIFORNIA

DEPARTMENT OF CORRECTIONS

PROBATION DEPARTMENT

PROBATION OFFICE

PROBATION OFFICER

PROBATION SUPERVISOR

PROBATION MANAGER

PROBATION DIRECTOR

PROBATION CHIEF

PROBATION CLERK

PROBATION ASSISTANT

PROBATION OFFICER

PROBATION SUPERVISOR

PROBATION MANAGER

PROBATION DIRECTOR

PROBATION CHIEF

PROBATION CLERK

PROBATION ASSISTANT

PROBATION OFFICER

DATE

TIME

BY

OFFICE

SECTION

DIVISION

DEPARTMENT

STATE

COUNTY

CITY

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PHONE

TELETYPE

RADIO

TELEVISION

INTERNET

EMAIL

MAIL

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DATE

TIME

BY

OFFICE

SECTION

DIVISION

DEPARTMENT

STATE

COUNTY

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