

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

Do not use this space.

File No. *6128*
Registered No. *127*
Ward

1. PLACE OF DEATH

County *Chase* Registration District No. *318*
Township *Springfield Mo* Primary Registration District No. *2991*
City *Springfield Mo* (No. *1000*)

2. FULL NAME

James O Chelers
(a) Residence. No. *Chase Mo* 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 01 - 1870*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>53</i>	<i>8</i>	<i>5</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housewife*
(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) *Ill.*

10. NAME OF FATHER *Markus Pester*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) *Ill.*

12. MAIDEN NAME OF MOTHER *Mary Ann Beck*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) *Ill.*

14. INFORMANT (Address) *J. O. Chelers RR #3 Chase Mo*

15. FILED *2-9-29* 19. *October 1906* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-6 1929*

17. I HEREBY CERTIFY, That I attended deceased from _____
Jan 1 1929 to *Feb 6 1929*
the last saw him alive on *Feb 6 1929*, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intoxication (Pulmonary Intercostosis)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) *Exhaustion*
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ (IF NOT AT PLACE OF DEATH) *Springfield Mo*

19. DID AN OPERATION PRECEDE DEATH? _____ DATE _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? *Cholera*
(Signed) *Chas Russell*, M. D.
48, 19 *21* (Address) *Springfield*

*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 *Person Cemetery* DATE OF BURIAL *2-9 1929*

20. UNDERTAKER *W. D. ...* ADDRESS *Springfield*

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. MAR 22 1929

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

