

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

Do not use this space.

6131

**1. PLACE OF DEATH**

County Laclede  
Towship Springfield  
City Springfield (No. ~~1000~~ 9)

Registration District No. 318  
Primary Registration District No. 5440

File No. ....  
Registered No. 131  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. TCFD. #9 St. .... Ward. ....  
(Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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) Jan 15 - 1856

7. AGE 73 YEARS MONTHS 0 DAYS 23 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St Charles (STATE OR COUNTRY) Mo

10. NAME OF FATHER John G Becker

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

12. MAIDEN NAME OF MOTHER Lacrina Simon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Mrs Lula Deckensheets (Address) Springfield Mo

15. FILED 2-9-21 1921 Cl. Horst REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 8 19 21

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 19 21 to Feb 9 19 21, 1921, that I last saw him live on Feb 8 19 21, and that death occurred, on the date stated above, at 8:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Apoplexy  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

**CONTRIBUTORY (SECONDARY)**

Myocardial  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) W. A. Shell, M. D.  
, 19 (Address) SPRINGFIELD, 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 Roberts Cemetery DATE OF BURIAL Feb 10 19 21

20. UNDERTAKER Anna L. Meyer 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

