MAR 23 1929

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

Do not use this space.

7138

1. PLACE OF DEATH
County Linn
Township Parson Creek
City Meadville (No. ..... St. ..... Ward)
Registration District No. 503
Primary Registration District No. 5664
File No. .....
Registered No. 5

2. FULL NAME Horace Clyde Pfander

(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 1 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: Mrs Minnie Pfander

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 25-1876

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
52	11	24	

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) (STATE OR COUNTRY): Clarinda Iowa

PARENTS
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): Ralph Pfander Wheeling Mo

15. FILED 2-18, 1929 E H Wein REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feby 18 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1928, to Feby 17, 1929, that I last saw him alive on Feby 17, 1929, and that death occurred, on the date stated above, at 2 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ascending Paralysis acute
(duration) yrs. 4 mos. 14 ds.

CONTRIBUTORY (SECONDARY): Influenza
(duration) yrs. 2 mos. 15 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at Place of Death
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W A Snope, M. D
2/18, 1929 (Address) Wheeling 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: Clarinda Iowa
DATE OF BURIAL: Feb. 20 1929

20. UNDERTAKER: Smiley Bros Meadville Mo
ADDRESS

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

1. PLACE OF DEATH.

County Linn — Registration District No. 503 — File No.

Township Parson Creek — Primary Registration District No. 5661 — Registered No. 5

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Horace Clyde Offenden

(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): M

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

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

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

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)

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Feb 18, 1939 — E F Weir — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 18 1939

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:

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

5-7138