

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

Do not use this space.
13694

PLACE OF DEATH -
 County Adair Registration District No. 4
 Township _____ Primary Registration District No. 3001
 City Kirkville Mo (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 66
 St. _____ Ward _____

2. FULL NAME Eschardt Duesler
 (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 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 Rather Duesler
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-2-1845
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 | 2 | 0 | _____
 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) Germany
 (STATE OR COUNTRY)
 10. NAME OF FATHER John Duesler
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Not known
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

14. INFORMANT Catharine Duesler
 (Address) Kirkville Mo.

15. FILED 4/4 1929 Ed Beck
Deputy REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 2 1929
 17. I HEREBY CERTIFY, That I attended deceased from 3-17 1929, to 4-2 1929, and that I last saw h. alive on 4-2 1929, and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis, chronic
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Pneumonia
 (duration) _____ yrs. _____ mos. 2 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) Ralph O. Stecklen, M. D.
 , 19 (Address) Kirkville 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 Novinger Mo DATE OF BURIAL 4-4 1929

20. UNDERTAKER Dee Riley ADDRESS Kirkville

1929-21-2
1845-2-2

84-2-0

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Edwards Registration District No. 4 File No. _____
 Townshp. _____ Primary Registration District No. 3001 Registered No. 66
 City Kirksville St. _____ Ward _____

2. FULL NAME

Euhart Deegler

(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 (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 _____
 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 7/12 1929 Ch. Becker REGISTRAR
Deput

MEDICAL CERTIFICATE OF DEATH

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

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) Pneumonia (duration) _____ yrs. mos. ds.
Lobar

18. WHERE WAS DISEASE CONTRACTED 1010
 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

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

5-13694

RECEIVED

OFFICE OF THE
DIRECTOR

1968