

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

Do not use this space.

21864

1. PLACE OF DEATH

County Jasper
Township
City Webb City, Mo (No. _____)

Registration District No. 417
Primary Registration District No. 3021

File No. _____
Registered No. 91
St. _____ Ward)

2. FULL NAME

Emerij Ehrhart

(a) Residence. No. 710 1/2th. Broadway 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 Lula Ehrhart

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29, 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 11 26.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Seneca
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Victor Ehrhart

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Carrie Reith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kansas
(STATE OR COUNTRY)

14. INFORMANT Mrs. Lula Ehrhart
(Address) Webb City, Mo

15. FILED 6/26, 1929 R. M. Stormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1929

17. I HEREBY CERTIFY that I attended deceased from June 9, 1929 to June 25, 1929
(the I last saw him alive on June 25, 1929 and that death occurred, on the date stated above, at 7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis - Spinal
60
(duration) yrs. 17 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) R. M. Stormont, M. D.

6/26, 1929 (Address) Mrs. C. E. 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 DATE OF BURIAL

Carterville June 27, 1929

20. UNDERTAKER ADDRESS

Steele Und. Co. Webb City, Mo.

PHYSICIAN'S OCCUPATION CLASSIFICATION

49
51929

24

2

N. B.—EVIDENCE OF DEATH

FEB 21 1956

**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 Jasper
Township Webb City
City Webb City (No.)

Registration District No. 417
Primary Registration District No. 3021

File No. 21864
Registered No.
St. Ward)

2. FULL NAME

Emory E. Clark

(a) Residence. No. 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 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 9/30 29 R. M. Sturmont REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis Spinal

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

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT AFFIX FEES FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

34

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