

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... (No.)

Registration District No. **791**
Primary Registration District No. **1003**
Anthony Massp

File No. **22849**
Registered No. **6265**
St. Ward)

2. FULL NAME: *Henry Speiser*

(a) Residence. No. *Belleville Ills* St. *24* Ward. *Belleville Ill*
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *W*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 9 1929*

17. I HEREBY CERTIFY, That I attended deceased from *June 9* 19*29*, to *June 9* 19*29*, that I last saw him alive on *June 9* 19*29*, and that death occurred, on the date stated above, at *12:45* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Respiratory Apoplexy

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 16 - 1861*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>67</i>	<i>6</i>	<i>24</i>	

8. OCCUPATION OF DECEASED

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

CONTRIBUTORY (SECONDARY) *74* (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) *New Baden Ills*
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER *Mike Speiser*

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
8 WAS THERE AN AUTOPSY?

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

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *J. H. Weissbrock* M. D.

12. MAIDEN NAME OF MOTHER *Ethelene Sadler*

(Address) *2000 S. 9*

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

*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.

14. INFORMANT *Ken Speiser*
(Address) *1208 Russell*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Salisbury Mo* DATE OF BURIAL *June 11 1929*

15. FILED *JUN 10 1929* *Max W. Stanley* REGISTRAR

20. UNDERTAKER *Bensiek-Nichols* ADDRESS *1138 N. 16th*

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.

