

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

Do not use this space.

27603

1. PLACE OF DEATH

Com. Mon
Township Arcadia
City..... (No.....).....St.....Ward.....

Registration District No. 394
Primary Registration District No. 5-5-4-6B

File No.....
Registered No. 10
.....St.....Ward.....

2. FULL NAME

Adolf Murtyko

(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 6 yrs. mos. da. How long in U.S., if of foreign birth? 23 yrs. mos. da.

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) Aug. 4-1881

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
48 | - | 7 | - | -

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) Hungary

10. NAME OF FATHER Andrew Murtyko

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

12. MAIDEN NAME OF MOTHER Susana Murtyko

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

14. INFORMANT M. Korotchich (Address) Plot Knob, Mo.

15. FILED Aug 13 1929 L. J. Effinger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 - 1929, to Aug 12 - 1929 that I last saw him alive on Aug 10 - 1929, and that death occurred, on the date stated above, at 6:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

CONTRIBUTORY (SECONDARY) 10/10/10 (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. H. Martin, M. D.

(Address) Frontier, 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 Plot Knob Catholic Cemetery DATE OF BURIAL Aug 14 1929

20. UNDERTAKER Allice ADDRESS Frontier, Mo.

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.

