

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

Do not use this space.

1. PLACE OF DEATH

County Cape Girardeau
Township Girardeau
City Girardeau (No. 126)

Registration District No. 126
Primary Registration District No. 2174 B

File No. 1424
Registered No. 126
St. 1 Ward)

2. FULL NAME

(a) Residence. No. Charles F. Ahrens St. 1 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

2. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

3A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 15 - 1904

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 3 20

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) Girardville
(STATE OR COUNTRY) Mo

10. NAME OF FATHER John H Ahren

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

12. MAIDEN NAME OF MOTHER Martha Newmyer

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

14. INFORMANT Otto Krehm
(Address) Girardville Mo.

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 3 - 1930, to Jan. 5 - 1930, that I last saw him alive on Jan. 5 - 1930, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Congestion
accompanied with
Croupous Pneumonia
(duration) yrs. mos. ds. 3 ds.

CONTRIBUTORY Fracture Left Leg - lower
(SECONDARY) third
(duration) yrs. mos. ds. 3 ds.

18. WHERE WAS DISEASE CONTRACTED at place of birth
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? N.O. DATE OF

WAS THERE AN AUTOPSY? N.O.

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) W. W. Ford M. D.

, 19 (Address) Girardville, 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 Zion M & Cemetery DATE OF BURIAL Jan 8 1930

20. UNDERTAKER Crocraft & Miller ADDRESS Jackson Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PRINTING, MO.

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**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 Cape Girardeau
Township Public
City St. Louis (No. 126)

Registration District No. 126
Primary Registration District No. 3774 B

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

2. FULL NAME

Charles F. Ahrens

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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)

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 _____, 19____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1930

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:

Pulmonary Congestion
Fracture of left leg
lower (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Fracture of left leg (duration) yrs. mos. da.

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

Every item of information should be stated EXACTLY. Every item of information should be properly classified. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. REGISTRATION should state every important. DESCRIBED BY LAW

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