

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

Do not use this space.

1. PLACE OF DEATH

County St. Charles Registration District No. 757
Township _____ Primary Registration District No. 3036
City St. Charles (No. 625 Houston)

File No. 2392
Registered No. 7
St. _____ Ward)

2. FULL NAME

Henry W. Achelpohl
(a) Residence. No. 625 Houston 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 Katherine Gregory
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24-1897
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 5 22

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St. Charles
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER William Achelpohl
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Friederica Achelpohl
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) _____

14. INFORMANT Irvin B. Achelpohl
(Address) St. Charles Mo.

15. FILED 1/8, 1930 by H. Bloebaum
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____
_____ 19____ to _____ 19____
that I last saw him alive on Jan 16, 1930, and that
death occurred, on the date stated above, at 5:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
87 A
50

(duration) _____ yrs. _____ mos. 1 ds.
CONTRIBUTORY Arterio Sclerosis
(SECONDARY)

(duration) 4 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Chemical Examination

(Signed) Charles Lyngstrom M. D.

(Address) 1-28, 1930 St. Charles 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 _____

Oak Grove Cemetery Jan 19 1930

20. UNDERTAKER _____

ADDRESS _____

H. Hallmeyer & Sons Co 800 N. 4th

WRITE PLAINLY WITH INK. 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.

