

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

Do not use this space.

Belton
4371

MAP 25 1930

1. PLACE OF DEATH

County *Chariton*

Registration District No. *175*

Township

Primary Registration District No. *17104*

City *Salisbury*

File No.

Registered No. *7*

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

St. _____

Ward _____

(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

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

Oct 10 - 1860

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

69

3

29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Home owner

(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)

Ill

10. NAME OF FATHER

Adam Gehrig

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

*R.A. Gehrig
Salisbury Mo*

15. FILED

3/1, 1930

R.W. Hawkins

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

2 - 9 1930

17.

I HEREBY CERTIFY, That I attended deceased from *1-29*

1930 to *2-9*, 19*30*

that I last saw him alive on *2-9*, 19*30*, and that death occurred, on the date stated above, at *4 am*.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
115A

CONTRIBUTORY (SECONDARY)

Streptococcus militaris (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *R.W. Hawkins*, M. D.

219, 19*30* (Address) *Salisbury Mo*

*State the DISEASE CAUSING DEATHS, 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

Salisbury Ill

2-11 1930

20. UNDERTAKER

ADDRESS

Winkelmeier Bros Salisbury

