

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

Do not use this space

③

1. PLACE OF DEATH

County Scott

Registration District No. 1151

Township Wells

Primary Registration District No. 60656

City Wells (No. _____)

File No. 1133928

Registered No. _____

St. _____ Ward _____

2. FULL NAME

John Blattel

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

single

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

Feb. 26-1930

7. AGE

YEARS

MONTHS

DAYS

4

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

single

9. BIRTHPLACE (CITY OR TOWN)

Wells mo

(STATE OR COUNTRY)

10. NAME OF FATHER

John Blattel

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Wells mo

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary Cullis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Wells mo

(STATE OR COUNTRY)

14. INFORMANT

John Blattel

(Address)

Wells mo

15. FILED

3-1-30 L. A. Scummen

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 1 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1930, to March 1, 1930 that I last saw him alive on Feb 28, 1930, and that death occurred, on the date stated above, at 10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia with
159

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

CONTRIBUTORY (SECONDARY)

159

(duration) _____ 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

(Signed) J. J. Jordan, M. D.

3-1-1930 (Address) Wells 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

Lightman Cem.

DATE OF BURIAL

3-2 1930

20. UNDERTAKER

Ch. Walter

ADDRESS

16th 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 very important.

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