

JUN 5 1930

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

Do not use this space.

12438

1. PLACE OF DEATH

County Shaver

Registration District No. 384

File No. 48

Township West Plains Mo.

Primary Registration District No. 4727

Registered No. _____

City West Plains Mo.

St. _____ Ward _____

2. FULL NAME

Clifford Eugene Kuitner

(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

ma

4. COLOR OR RACE

wht

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

married

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

Belle Kuitner

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

aug 8 - 1908

7. AGE

YEARS 26

MONTHS _____

DAYS _____

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

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)

Oregon, Co.

(STATE OR COUNTRY)

10. NAME OF FATHER

V. S. Kuitner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Indiana

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary Curry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Indiana

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Mrs. L. E. Kuitner
West Plains Mo

15.

FILED

4 30 30

O. P. Keimick

REGISTRAR

3. MEDICAL CERTIFICATE OF DEATH

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

4/29 - 1930

17.

I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 29th, 1930.
that I last saw him alive on April 22, 1930 and that death occurred, on the date stated above, at 3:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis, chronic with valvular disease.

92A

93C

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Chronic Hypertension

(duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

90A

IF NOT AT PLACE OF DEATH Koshkonong, Mo

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical

(Signed) W. H. Shaul M. D.

4/30/30 (Address) West Plains, 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

Koshkonong Cemetery

4/30 1930

20. UNDERTAKER

ADDRESS

M. J. J. J. J.

West Plains 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.

25-8-20

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1914

**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 Howell Registration District No. 384 File No.
Township Primary Registration District No. 4227 Registered No. 48
City West Plains No. St. Ward)

2. FULL NAME

Clifford Eugene Kintner
(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 9 - 1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 22 - X 8 X 20 X

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 4-30-30 000 Humbert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/29 19 30

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19....., and that I last saw him/her on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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) MAKE AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information ab- are fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12438