

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.

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

Do not use this space.  
**16423**

**1. PLACE OF DEATH**

County Jackson  
 Township Prairie  
 City (No. ....)

Registration District No. Hoo  
 Primary Registration District No. 10

File No. ....  
 Registered No. 69  
 St. .... Ward)

**2. FULL NAME** Otto Bahl

(a) Residence. No. Jackson County St. Louis 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-6-1846

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
84 1 27 24

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. chemist  
 (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) Germany

10. NAME OF FATHER Anton

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

12. MAIDEN NAME OF MOTHER unk

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

14. INFORMANT J. W. Hosteller

15. May 4 1930 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-3-1930

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1930 to May 3, 1930  
 that I last saw him alive on May 2, 1930, and that death occurred, on the date stated above, at 3 o'clock a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

acute gastro-enteritis  
120 B  
114 B  
 (duration) yrs. mos. 7 ds.  
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
 (Signed) J. W. Greese, M. D.  
7/3, 1930 (Address) Independence 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 Kirksville DATE OF BURIAL 5/10/30  
Oskoppath  
 20. UNDERTAKER Ketterling ADDRESS unk

