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

Do not use this space.

19129

File No. ____
Registered No. 4128

1. PLACE OF DEATH
County: Greene — Registration District No.: 518
Township: ____ — Primary Registration District No.: 2001
City: Springfield (No. 801 N. Broadway St. ____ Ward)

2. FULL NAME: Boris Kagel
(a) Residence. No. 801 N. Broadway St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 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): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 8 1895

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
35	4	27	

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: Housewife
(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): Mo.

PARENTS
10. NAME OF FATHER: Geo Blakey
11. BIRTHPLACE OF FATHER (CITY OR TOWN): ____
(STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Harley Towns
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): ____
(STATE OR COUNTRY): Ark.

14. INFORMANT: Mrs. G. Blakey
(Address): 801 N. Broadway Sp

15. FILED 6-9, 1930 — Geo Sharp, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6-3-1930

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to 6-3-1930, that I last saw him alive on 6-3-1930, and that death occurred, on the date stated above, at 7 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
1 yr.
1 yr.
(duration) ____ yrs. 3 mos. ____ ds.

CONTRIBUTORY (SECONDARY): Ruptured Bowel
(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ____
DID AN OPERATION PRECEDE DEATH? yes DATE OF ____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) C. V. Russell, M. D.
6, 1930 (Address) Springfield 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: Greenwood — DATE OF BURIAL: 6-9 1930

20. UNDERTAKER: W. Harris — ADDRESS: Springfield

JUL 22 ... Failure to give information of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Greene
Township
City Springfield (No. ..... St. ..... Ward)
Registration District No. 318
Primary Registration District No. 2001
File No. .....
Registered No. 428

2. FULL NAME Rosie Kagel
(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 F
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)

7. AGE — YEARS — MONTHS — DAYS — 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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
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 6/9 1930 Lou Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
Adhesions
..... (duration) ..... yrs. ..... mos. ..... ds.
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) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

... be properly classified. Exact statement of OCCUPATION is very important.

S-19129