

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

Do not use this space.

21022

~~21020~~

File No. _____
Registered No. **5854**.
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **701**
Township _____ Primary Registration District No. **1003**
City **St. Joseph** No. _____

2. FULL NAME

(a) Residence. No. **4500 Washington St.** Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred **9** yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

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) July 12 1857		
7. AGE	YEARS 76	MONTHS 11
	DAYS 3	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Day Laborer (b) General nature of industry, business, or establishment in which employed (or employer). Odd jobs (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany		
PARENTS	10. NAME OF FATHER Conrad Seukler	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany	
	12. MAIDEN NAME OF MOTHER Ely Truck	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany	
14. INFORMANT (Address) John Storkel		
15. FILED 17 1930 REGISTRAR		

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 15 1930**

17. I HEREBY CERTIFY, That I attended deceased from **June 3**, 19**30**, to **June 15**, 19**30** that I last saw him alive on **June 15**, 19**30** and that death occurred, on the date stated above, at **3:00 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
**Chronic Myocarditis
Generalized Arterial
Sclerosis**

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? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Physical**
(Signed) **Carl H. Hotz**, M. D.
6-16-30 (Address) **City St. Joseph**

*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 St. Johns Cemetery Melville	DATE OF BURIAL 6/18 1930
20. UNDERTAKER Southern W.L.C.	ADDRESS 6320 So. Grand

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Seeds.