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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.

22504

1. PLACE OF DEATH
County Gasconade
Township Canaan
City ..... (No. ..... St. ..... Ward)
Registration District No. 305
Primary Registration District No. 5472
File No. .....
Registered No. 19

2. FULL NAME William ~~Sholand~~ Scholand
(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: 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 - 18 - 1844
7. AGE: Years 86, Months 4, Days 3; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(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

PARENTS
10. NAME OF FATHER: William Scholand
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Guetemeyer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Fred Adel
(Address) Owensville Mo

15. FILED 7-23, 1930. J. J. Ferrell, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-21 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to 7-21, 1930, that I last saw his ~~[illegible]~~ alive on 7-21, 1930, and that death occurred, on the date stated above, at 4 20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Uremic Poison
131
132 B
..... (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Edw Mellies, M. D
7-22, 1930 (Address) Owensville 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: Owensville cemetery
DATE OF BURIAL: 7-23 1930
20. UNDERTAKER: W. F. Gottenstracker, Owensville, Mo
ADDRESS

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: Gasconade — Registration District No.: 305 — File No.:
Township: Canaan — Primary Registration District No.: 34 — Registered No.: 19
City: (No. , St. Ward)

2. FULL NAME: William Scholand

(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): S

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 7-23, 1930. J. J. Ferrell, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21, 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:
Uremia Poisoning
Chronic nephritis
(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

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CAUSE OF DEATH in plain terms, so that it may be classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-22504