

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

Do not use this space.

22691

1. PLACE OF DEATH
 County Howell Co Mo Registration District No. 389
 Township Wyanne Primary Registration District No. 5343
 City (No. _____) St. _____ Ward _____

2. FULL NAME George Birk
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No. 6.
 Registered No. _____

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) Jan 6th 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>84</u>	<u>6</u>	<u>2</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farming
 (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) Cincinnati, Ohio

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT J. D. Crow
 (Address) Washburn Mo

15. FILED July 11 1930
John Morgan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July - 9 - 1930

17. I HEREBY CERTIFY, That I attended deceased from July 7 - 1930 to July 7 - 1930
 that I last saw him alive on July 7 - 1930, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Apoplexy
82A

CONTRIBUTORY (SECONDARY) 74
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. Frank Fuller, M.D.
 (Address) Washburn 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 Wayside Cem **DATE OF BURIAL** July 10 1930

20. UNDERTAKER Wayside Cem **ADDRESS** _____

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.

AUG 26 1930

no modification

