

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

Do not use this space.

26364

1. PLACE OF DEATH

County Gasconade Registration District No. 304
 Township Richland Primary Registration District No. 572
 City Milton (No. _____) St. _____ Ward _____

2. FULL NAME

Milton Seifert
 (a) Residence. No. _____ 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 _____
Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-24-1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
23 11 5

8. OCCUPATION OF DECEASED 1906
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) Government Work
 (c) Name of employer _____

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

10. NAME OF FATHER Leo Seifert

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

12. MAIDEN NAME OF MOTHER Rosa Mendley

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

14. INFORMANT Sheila Seifert
 (Address) 11 Morrison Ave

15. FILED 8-9-30 F. Kicker
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1930 to Aug 5 1930
 that I last saw him live on Aug 5 1930, and that death occurred, on the date stated above, at 9:11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental Struck by Piling
 (duration) yrs. mos. ds. 1

CONTRIBUTORY (SECONDARY) 20
 (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?
 (Signed) Howard Korfman, M. D.
 , 19 (Address) Pershing 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 Good Hope Cemetery DATE OF BURIAL 8-7-30

20. UNDERTAKER Arnold Hummert ADDRESS Morrison Ave

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.

