

42
SEP 24 1930

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

Do not use this space.

1. PLACE OF DEATH

County Newey Clinton Registration District No. 347
Township Desperater Primary Registration District No. 5488
City (No. _____) St. _____ Ward _____

File No. 26498
Registered No. 61

2. FULL NAME Chas Augustus Staudke

(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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lulu Staudke
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 17 - 1876
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 8 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Rocky Ridge
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER Wm Staudke
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Caroline Heinitzer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY) _____

14. INFORMANT Geo F Staudke
(Address) _____

15. FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-18 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 1929, to Aug 18, 1930
that I last saw him alive on Aug 18, 1930, and that death occurred, on the date stated above, at 7 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hodgkins disease

72 B
65 B
(duration) 2 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? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physician
(Signed) G. S. Walker, M. D.

(Address) Clinton 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 Englewood Cem DATE OF BURIAL 8/19 1930

20. UNDERTAKER Spare & Saw ADDRESS Clinton Missouri

VOIDING INK

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.

**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 Henry
Township Clinton
City Clinton (No.)

Registration District No. 347
Primary Registration District No. 7488

File No.
Registered No. 61
St. Ward

2. FULL NAME

(a) Residence. No. St., Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

Chas Augustus Standke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

6A. 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)

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)

FILED 8/19/30 Dr. E. C. Peelon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/18 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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

20. UNDERTAKER

ADDRESS

19

WRITE IN THIS SPACE WITH UNWRITING INK - THIS IS PERMANENT RECORD

N. B. - This form is to be filled out by the physician, or other person, who has attended the deceased, and who is best qualified to state the cause of death. It may be prepared, classified, and filed by the registrar, but it must be filled out by the physician, or other person, who has attended the deceased, and who is best qualified to state the cause of death. It may be prepared, classified, and filed by the registrar, but it must be filled out by the physician, or other person, who has attended the deceased, and who is best qualified to state the cause of death.

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

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