

SEP 25 1930

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

Do not use this space.

27343

1. PLACE OF DEATH

County *Montgomery*
Township *Walden*
City *California* (No. _____) St. _____ Ward _____

Registration District No. *571*
Primary Registration District No. *4335*

File No. _____
Registered No. *44* St. _____ Ward _____

2. FULL NAME

John Henry George Gathman

(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

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 21-1853

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

37

1

2

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)

Judonia

10. NAME OF FATHER

Henry Gathman

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

Germany

12. MAIDEN NAME OF MOTHER

Don't know

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

Germany

14. INFORMANT

Louise Gathman
(Address) *California Mo.*

15. DATE

Aug 25, 1930

James H. Gathman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-23* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from *8-16*, 19*30* to *8-23*, 19*30*, that I last saw him alive on *8-23*, 19*30*, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stens-Salerosis
1060
97

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Bronchitis

(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) *H.R. Popejoy*, M. D.

(Address) *California 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

City Center

DATE OF BURIAL

8/25 19*30*

20. UNDERTAKER

William & Fredman California

ADDRESS

California

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.

