

OCT 30 1930

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

Do not use this space.

30530

1. PLACE OF DEATH

County Miller
Township Salisse
City Eldon (No.)

Registration District No. 561
Primary Registration District No. 4320

File No.
Registered No. 69
St. Ward)

2. FULL NAME

Thomas A Eilerts

(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 Grace Johnson Eilerts

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25, 1870

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 Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Musical instruments
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Chapin
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER Thomas Eilerts

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

12. MAIDEN NAME OF MOTHER Henerida Hopkins

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

14. INFORMANT Grace Eilerts
(Address) Eldon, Mo

15. FILED 9-30 1930 Belle Haynes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-25, 1930 to 9-29, 1930 that I last saw him alive on 9-29, 1930, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Auto (collation of) burst
930
9513
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) myocarditis
(duration) 2 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) E. G. Shelton, M. D.

, 19 (Address) Eldon 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 Whitewater, Kansas DATE OF BURIAL 10-1 1930

20. UNDERTAKER W A Phillips ADDRESS Eldon, Mo.

-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

9-9-10-4

**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 Miller Registration District No. 561 File No. _____
 Township _____ Primary Registration District No. 4330 Registered No. 63
 City Eldon (No. _____) St. _____ Ward _____

2. FULL NAME

Thomas A. Cilenta

(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) M

5A. If MARRIED, WIDOWED, OR DIVORCED
 HUSBAND or (or) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 X 10 X 4 X

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) _____

15.

FILED 9-30 30 Belle Haynes
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

20. UNDERTAKER _____ ADDRESS _____

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION of DECEASED should be given. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-30530