NOV 21 1930

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

Do not use this space.

1. PLACE OF DEATH
County Cape Girardeau — Registration District No. 125 — File No. 32284
Township " " — Primary Registration District No. 3009 — Registered No. 537
City " " (No. St Francis Hospital St. 8 Ward)

2. FULL NAME August Schlitt
(a) Residence. No. Bell City Mo 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. 7 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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 3 - 1865

7. AGE: YEARS 65 — MONTHS 9 — DAYS 20 — If LESS than 1 day, ...hrs. or ....min.

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) (STATE OR COUNTRY): Germany

PARENTS
10. NAME OF FATHER: Jacob Schlitt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Mary Ann Wahl
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: E M Owen
(Address) Bell City Mo

15. FILED 10/21 1930 Cec Kaemfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct - 16, 1930, to Oct 23, 1930 that I last saw him alive on 10/22/30 and that death occurred, on the date stated above, at 1:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Urinary Extravasation
137
136B (duration) yrs. mos. 10 ds.
CONTRIBUTORY (SECONDARY) Prostatic Abscess
(duration) yrs. mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: Bell City Mo
DID AN OPERATION PRECEDE DEATH? yes DATE OF 10/19/30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [illegible], M. D.
, 19 (Address) Cape Girardeau 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: Advance St Joseph Cemetery — DATE OF BURIAL: Oct 25 1930

20. UNDERTAKER: Larberg F & N Co — ADDRESS: Cape Gir. Mo

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.