DEC 22 1930

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

Do not use this space. (E)

33565

1. PLACE OF DEATH

County Miller — Registration District No. 564 — File No.

Township Equality — Primary Registration District No. 5158 — Registered No.

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME John Karlgene Kallenbach

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 19, 1924

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	6	6	14	

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) Miller County
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Oliver R. Kallenbach

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miller County, Missouri

12. MAIDEN NAME OF MOTHER Carrie Ball

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miller County, Missouri

14. INFORMANT .....
(Address)

15. FILED ....., 19..... A.H. Koenig
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1930, to October 3, 1930 that I last saw him alive on October 3, 1930, and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Anterior poliomyelitis

(duration) ....yrs. ....mos. 7 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? Spinal Fluid examination

(Signed) E. K. Nilsson, M.D., 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: Duscumbia, Missouri — DATE OF BURIAL: 10 - 4 1930

20. UNDERTAKER: W. A. Phillips — ADDRESS: Eldon, Mo.

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.