

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

Do not use this space.

25434

File No. 28
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH
 County Jefferson Registration District No. 423
 Township Rock Primary Registration District No. 5578
 City Unknown (No. _____ St. _____ Ward)

2. FULL NAME Unknown
 (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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>Unknown</u>				

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Unknown
 (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) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____ 19____

17. I HEREBY CERTIFY, That I attended deceased from _____ 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:
Heart Distention
162 (duration) _____ yrs. _____ mos. _____ ds.
191 (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH at place of death
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings
 (Signed) O. Kerch, M. D.
 _____ 19____ (Address) Farmerswick Mo Rt 2

*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.

14. INFORMANT (Address) _____

15. EX. 72 1931 H. M. Stel REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Burgess Cemetery DATE OF BURIAL July 4 1931
 20. UNDERTAKER Prof. H. Heiligtag ADDRESS Farmerswick

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.

25 1931

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