

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

Do not use this space.

30403

1. PLACE OF DEATH

County Worth
Township Wetchall
City Grant City (No. _____)

Registration District No. 903
Primary Registration District No. 0212

File No. _____
Registered No. 21
St. _____ Ward _____

2. FULL NAME

Michael Wetchall
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Rebecca Wetchall

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 3, 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 3 26

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) same
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Grant City
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER William Wetchall

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

12. MAIDEN NAME OF MOTHER Eddie Wetchall

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

14. INFORMANT Albert Wetchall
(Address) Grant City, Mo.

15. FILED 9-10-31 John Auerens
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 29 1931

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1931 to Aug 29, 1931 that I last saw him alive on Aug 28, 1931 and that death occurred, on the date stated above, at 302 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Medical respiration
92A

(duration) 2 yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 92A
(duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Physician's findings
(Signed) [Signature] M. D.

(Address) Grant City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Grand River Chapel DATE OF BURIAL 8/30 1931

20. UNDERTAKER Arch C. Dumper ADDRESS Grant City

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.

SEP 28 1931

