

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

Do not use this space.

9728 <sup>a</sup>

1. PLACE OF DEATH *Miller Equality*  
 County *Equality* Registration District No. *364*  
 Township *Equality* Primary Registration District No. *59131*  
 City *Juscumb* (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

2. FULL NAME *Awat Holtzrichter*  
 (a) Residence. No. *County Fern* St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**(2) MEDICAL CERTIFICATE OF DEATH**

3. SEX *m* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *?*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-27* 19*34*

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

17. I HEREBY CERTIFY, That I attended deceased from *3-15*, 19*34*, to *3-23*, 19*34*, that I last saw him alive on *3-26*, 19*34*, and that death occurred, on the date stated above, at *4:00* p.m.

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*Very old*

*Diabetes mellitus, 57 with a secondary bronchopneumonia 9:30 (duration) 20 yrs. mos. ds.*

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *County Pauper*  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY *Chafagny syndrome* (SECONDARY) (duration) *15* yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) *Germany* (STATE OR COUNTRY)

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

10. NAME OF FATHER *unknown*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF \_\_\_\_\_

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

WAS THERE AN AUTOPSY? *no*

12. MAIDEN NAME OF MOTHER *Dr. A. A. A.*

WHAT TEST CONFIRMED DIAGNOSIS? *sugar in urine*

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

(Signed) *D. H. Kowen*, M. D.

, 19 (Address) *Juscumb*

\*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) \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Mt. Zion* DATE OF BURIAL *3-28* 19*34*

15. FILED *3-28-34* *D. H. Kowen* REGISTRAR

20. UNDERTAKER *H. Wright* ADDRESS *Juscumb*

Every item of information should be carefully checked. 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.

JUN 23 1934

