

MAY 25 1934

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

Do not use this space.

13163

1. PLACE OF DEATH

County JACKSONRegistration District No. 399Township KAWPrimary Registration District No. 1002City KANSAS CITY(No. 4941; LYDIA)File No. 1910Registered No. 1910

St. _____ Ward _____

2. FULL NAME CHARLES FALK(a) Residence, No. 4941 - LYDIA St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

MALE WHITE WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OFMRS. LILLIE FALK6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 8. 1862

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

72321

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

TELEGRAPHER

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

POSTAL TEL. CO.10. Date deceased last worked at this occupation (month and year) 1929

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) JEFFERSON CITY
(STATE OR COUNTRY) MISSOURI13. NAME UNKNOWN FALK14. BIRTHPLACE (CITY OR TOWN) GERMANY
(STATE OR COUNTRY)15. MAIDEN NAME MARY UNKNOWN16. BIRTHPLACE (CITY OR TOWN) GERMANY
(STATE OR COUNTRY)17. INFORMANT MRS. WILLIAM J. PALMER
(ADDRESS) 4941 - LYDIA AVE.

18. BURIAL, CREMATION, OR REMOVAL

PLACE FOREST HILL DATE MAY-2 193419. UNDERTAKER D. W. NEWCOMER'S SONS
(ADDRESS) 2111 EAST 9TH ST.20. FILED 4-30 1934 mmmm
dash Registrar.21. DATE OF DEATH (MONTH, DAY, AND YEAR) APRIL 29. 193422. I HEREBY CERTIFY, That I attended deceased from Jan 1933, to April 25 1934I last saw him alive on April 25 1934 Death is said to have occurred on the date stated above, at 5:30 P.M.

The principal cause of death and related causes of importance were as follows:

Epileptiforma of face - nose & eyesDisease extending to brainOther contributory causes of importance: SVDate of onset 10. 1933

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? WRIf so, specify E. O. Smith M. D.(Signed) E. O. Smith (Address) 214 Kabash

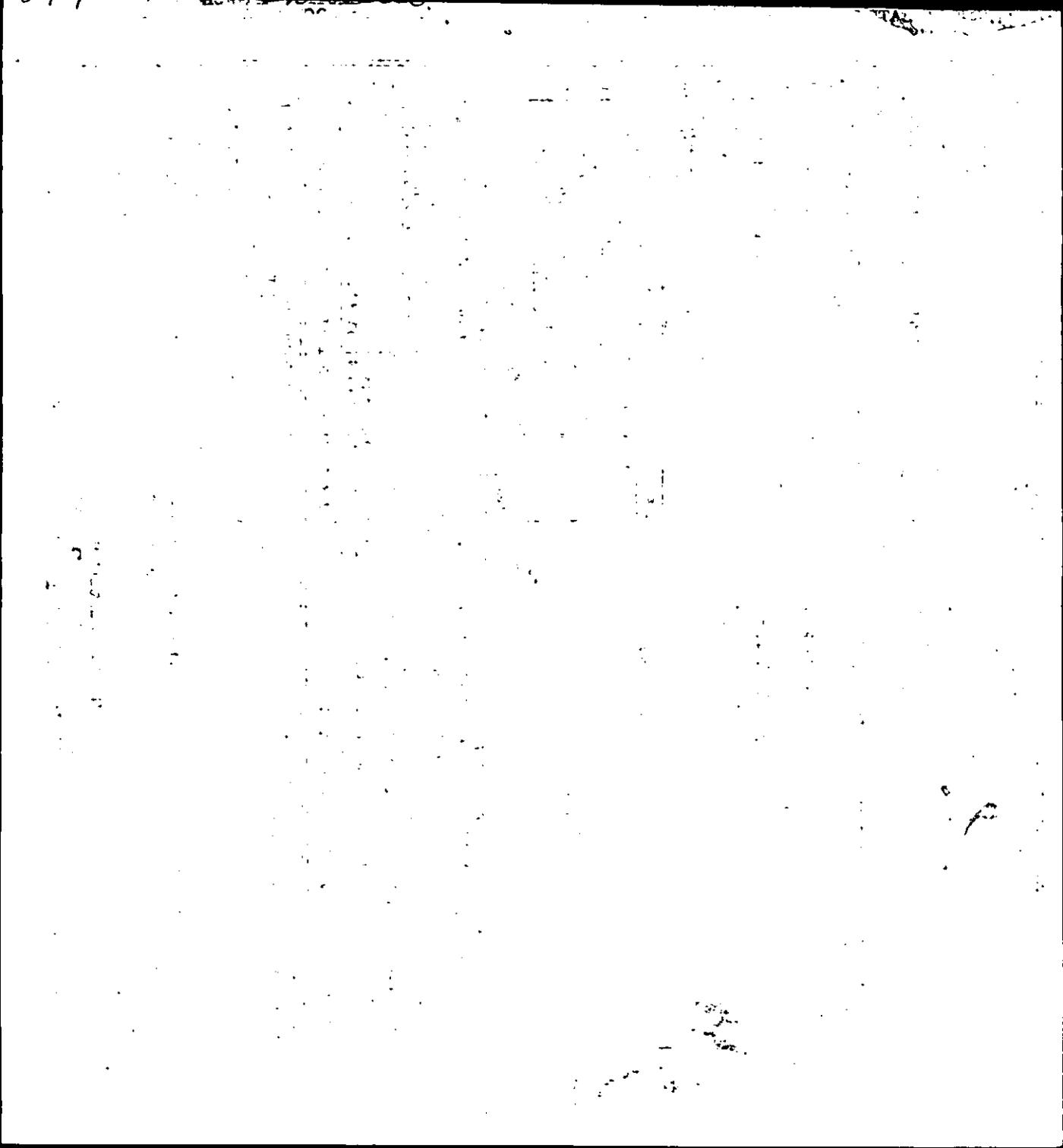
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCCUPATION

FATHER

MOTHER

1
10
10



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township St. Louis
City St. Louis (No. 1002)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 19146 St. _____ Ward _____

2. FULL NAME

Charles Galk

(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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid (write the word)

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

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. UNDERTAKER (ADDRESS)

20. FILED 4/30 1934 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 29, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the _____ m.

The principal cause of death and related causes of importance were as follows:

Cephaloma of the brain + nose + lungs disease extending to brain

Other contributory causes of importance: Primary, Chcek

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

45

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-13163

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Raw Primary Registration District No. _____
City Keosauqua (No. 4941) Hyden St. _____ Ward _____

File No. _____
Registered No. 1914
St. _____ Ward _____

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

The principal cause of death and related causes of importance were as follows: _____

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Swollen face
upper eye and brain
Epithelioma started on left
check near nose and one inch
below eye - extended over nose
Other contributory causes of importance: *to Right Eye*
sitting nose & eye out
and the doubt epithelioma
the brain

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Name of operation _____ Date of _____

13. NAME _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

15. MAIDEN NAME _____

Where did injury occur? _____ (Specify city or town, county, and State)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Specify whether injury occurred in industry, in home, or in public place. _____

17. INFORMANT (ADDRESS) _____

Manner of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

Nature of injury _____

19. UNDERTAKER (ADDRESS) _____

24. Was disease or injury in any way related to occupation of deceased? _____

20. FILED 4-30-34 M. M. Browne Registrar

If so, specify _____ (Signed) E. C. Smith, M. D.

(Address) 214 Graham

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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