

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

Do not use this space.

1. PLACE OF DEATH

County Bates Registration District No. 50 File No. 15695
 Township _____ Primary Registration District No. 3004 Registered No. 40
 City Butler (No. _____) St. _____ Ward _____

2. FULL NAME Lawrence J. Deels

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25, 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 1 28

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

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) Bates Co Missouri

13. NAME Jefferson Deels

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Butler, Mo

15. MAIDEN NAME Ann Kraw

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Butler, Mo

17. INFORMANT (ADDRESS) Dr. J. L. Gentry, Butler, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill DATE May 26, 1934

19. UNDERTAKER (ADDRESS) Butler, Mo

20. FILED May 24, 1934 Anna L. Cullen Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23rd, 1934

22. I HEREBY CERTIFY That I attended deceased from May 1931, 1930 to May 23, 1934

I last saw him alive on June 2, 1934. Death is said to have occurred on the date stated above, at _____ m.

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

Chronic Myocarditis Date of onset 1931
Infected Prostate ✓
Removal of Prostate Date May 1934

Other contributory causes of importance: _____

Name of operation _____ Date _____

What test confirmed diagnosis? _____ Was there an autopsy? No

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? No

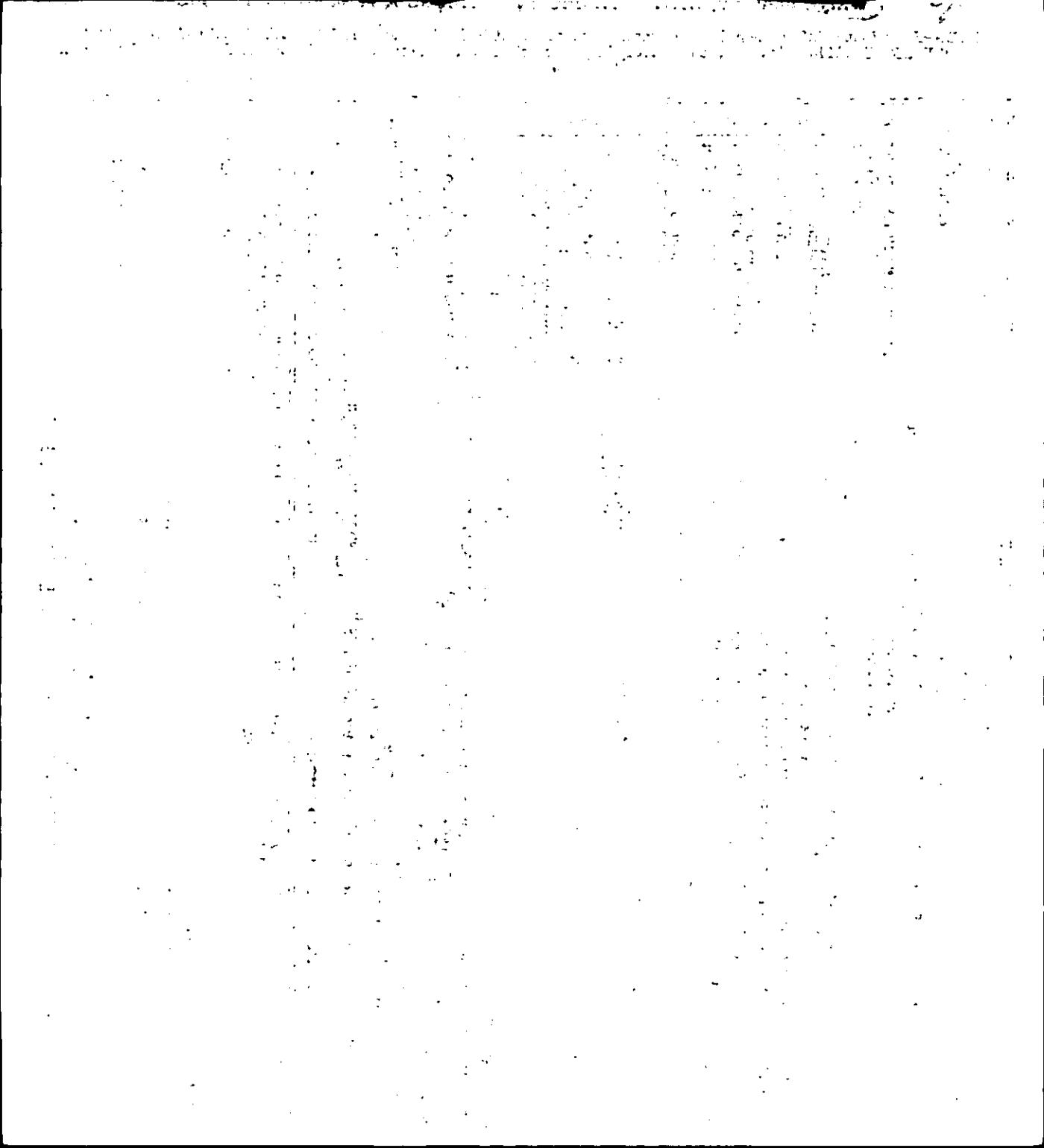
If so, specify _____ (Signed) L. D. Gentry, M. D.

(Address) Butler, 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.

JUN 20 1934

WHILE FAINTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD



#2 Bates

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

15695-

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Camer J Sells

Who died at _____ on May - 23 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 76 Months 1 Days 28

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Chronic Myocarditis 93 C

Other contributory causes of importance Infected Prostate

Name of operation Prostatectomy Date of _____

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

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 _____

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

If so, specify _____

Name of physician W D G. King M.D.

Address of physician Butler Mo.

Signature of Registrar Nina E. Culver. Butler Mo.

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 50

Very truly yours,

Primary Reg. Dist. No. 3004

E. T. McGaugh, M.D.
Special Agent.

STANDARD TELEPHONE & TELEGRAPH

COMMUNICATIONS DEPARTMENT

NEW YORK

TO: NEW YORK

FROM: NEW YORK

RE: NEW YORK

DATE: NEW YORK

TIME: NEW YORK

CLASS: NEW YORK

STATUS: NEW YORK

REMARKS: NEW YORK

OPERATOR: NEW YORK

RECEIVED: NEW YORK

S-157695

S-157695

Dr. Lee. 7/11/51

STANDARD TELEPHONE & TELEGRAPH
COMMUNICATIONS DEPARTMENT
NEW YORK