

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

Do not use this space.

1. PLACE OF DEATH

County Dickinson
Township St. Johns Mo.
City St. Johns Mo. (No.)

Registration District No. 85
Primary Registration District No. 1001

File No. 23270
Registered No. 776
St. Ward)

2. FULL NAME

(a) Residence, No. 917 S. 8th St., Ward.

(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 (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1894

7. AGE YEARS 60 MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE July 7 1934

19. UNDERTAKER (ADDRESS)

20. FILED 7-9-34 1934 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 3 1934

22. I HEREBY CERTIFY, that I attended deceased from July 2 1934 to July 3 1934
I last saw him alive on July 2 1934 Death is said to have occurred on the date stated above, at 12 noon m.
The principal cause of death and related causes of importance were as follows:

Chronic Pyelonephritis
133 P
130 P
130 P
Date of onset

Other contributory causes of importance:
Pharyngeal cystitis
nasal stenosis

Name of operation None 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) Chas. Greenberg, M. D.
(Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

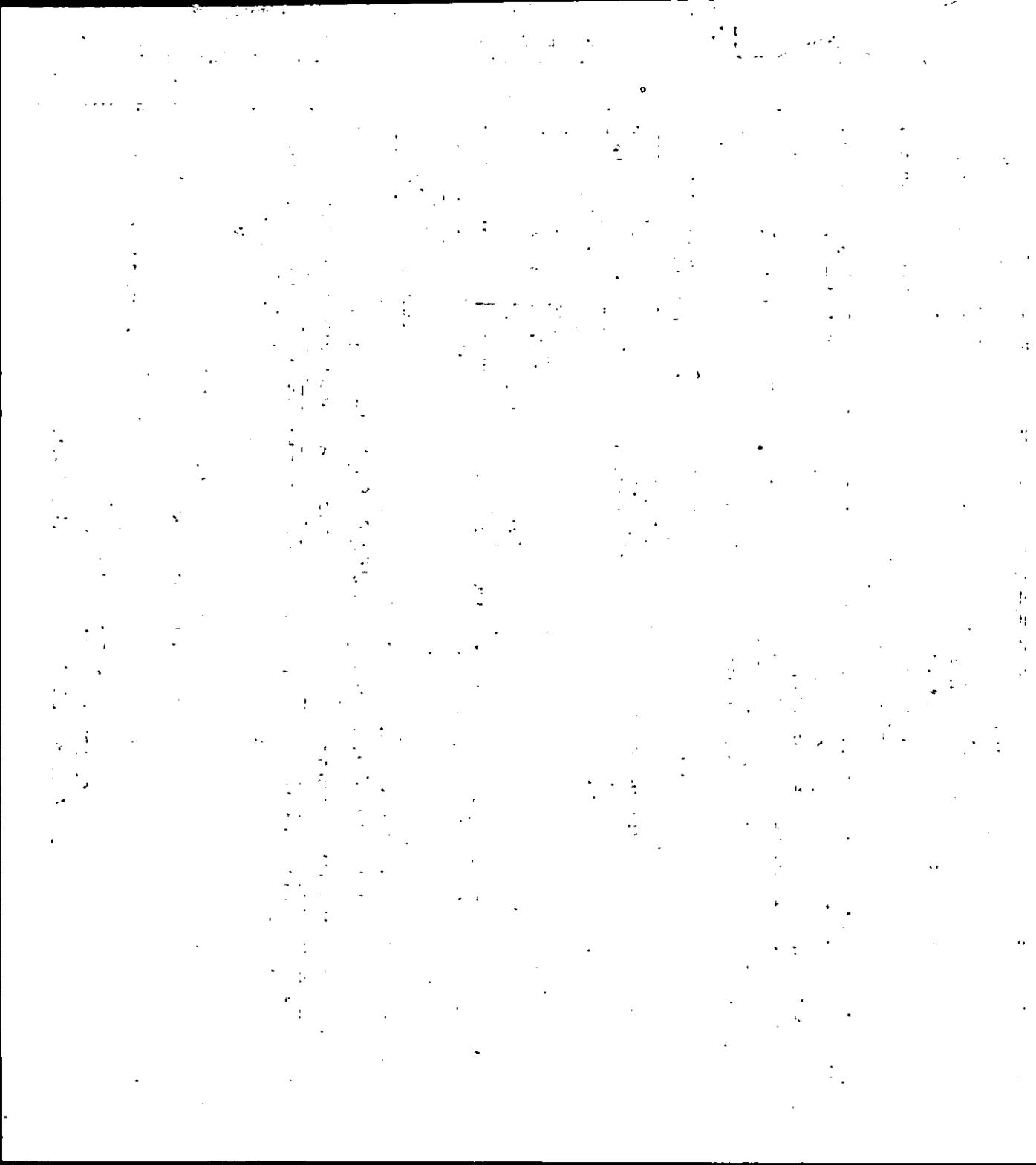
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 14 1934

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St Joseph

WASHINGTON

23270

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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: Ed Kachler
Who died at _____ on July 3 - 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: ^{abt} Years 60 Months _____ Days _____

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: Chronic Pyelonephritis Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) Not Calculous Pyelonephritis
Birthplace of mother (State or country) _____
Principal cause of death: the cystitis urethral stricture

Other contributory causes of importance _____
Name of operation _____ 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 Chas Greenberg
Address of physician St Joseph Mo
Signature of Registrar John R. Bender Date filed _____

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. 85

Very truly yours
E. T. McLaugh
State Registrar

Primary Reg. Dist. No. 1001

Special Agent.

S-23270