

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.

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

Do not use this space.
30375

1. PLACE OF DEATH
 County Phelps Registration District No. 677
 Township _____ Primary Registration District No. 4403
 City Rolla (No. _____) St. _____ Ward _____
2. FULL NAME Larence E. Kolb
 (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 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>6-10-1910</u>		
7. AGE YEARS <u>24</u>	MONTHS <u>2</u>	DAYS <u>21</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Truck Driver</u>		
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) <u>8-20-34</u>		11. Total time (years) spent in this occupation <u>5-7/2</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St James Mo</u>		
13. NAME <u>Herman Kolb</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St James Mo</u>		
15. MAIDEN NAME <u>Luey M. Gucker</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St James Mo</u>		
17. INFORMANT <u>Herman Kolb</u> (ADDRESS) <u>St James Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Masonic Cem</u> DATE <u>9-2-1934</u>		
19. UNDERTAKER <u>J. E. Lickler</u> (ADDRESS) <u>St James Mo</u>		
20. FILED <u>Sept 2 1934</u> <u>Jos. F. Cyren</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-31, 1934
 22. I HEREBY CERTIFY, That I attended deceased from 8-24, 1934 to 8-31, 1934
 I last saw him alive on Aug 31, 1934 Death is said to have occurred on the date stated above, at 12⁰⁰ P. m.
 The principal cause of death and related causes of importance were as follows:
Appendicitis
12/15
 Other contributory causes of importance _____
 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) W. J. McFarland, M. D.
 (Address) Rolla, Mo.

