

OCT 23 1935

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

Do not use this space.

30948
7740

1. PLACE OF DEATH

County.....
Township.....
City.....
#8221

Registration District No. 79i
Primary Registration District No. 1003

File No.....
Registered No.....
St. Ward)

2. FULL NAME

(a) Residence, No. 763 N. Euclid St. Ward. 12
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 3 1892*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *43 1 11 19*

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

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) *Clatsworth Oregon*

13. NAME *Benny Scheid*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Duwig Ill*

15. MAIDEN NAME *Nellie Wentz*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clatsworth Oregon*

17. INFORMANT *Wasp Inf. District* (ADDRESS) *City St. #1*

18. BURIAL, CREMATION OR REMOVAL PLACE *Clarksville Mo* DATE *9/16 1935*

19. UNDERTAKER *Arthur J. Donnelly* (ADDRESS) *3540 Dunell St.*

20. FILED *SEP 15 1935* Registrar. *J. Bredeck*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 14 1935*

I HEREBY CERTIFY, That I attended deceased from *8/23* 1935, to *Sept 14* 1935. I last saw him alive on *Sept 14* 1935. Death is said to have occurred on the date stated above, at *2:30* p.m. The principal cause of death and related causes of importance were as follows:

Ca. Valva Date of onset *8/23/35*

Other contributory causes of importance: *49*

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *g?*

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) *A. B. Collins*, M. D.
(Address) *City St. #1*

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.

