

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.

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

Do not use this space.

**JUN 8 1936**

18012

**1. PLACE OF DEATH:**

County.....  
Township.....  
City.....  
No. 15-983

Registration District No. 791  
Primary Registration District No. 1008  
City.....

File No.....  
Registered No. 5574  
St..... Ward.....

**2. FULL NAME**

(a) Residence, No. 310 2nd St., 25 Ward.  
(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 *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) *May 14-1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
*74 11 6*

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

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) *Linn County, Missouri*

13. NAME *Frank Richter*

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

15. MAIDEN NAME *Lizzie Wink*

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

17. INFORMANT *John Richter* (ADDRESS) *City, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington U* DATE *5-21-36*

19. UNDERTAKER *W Richter* (ADDRESS) *3530 Cutler St*

20. FILED *J.F. Bredeck* Registrar.

**MAY 27 1936**

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/20/36* 19

22. I HEREBY CERTIFY, That, I attended deceased from *4/19*, 19*36* *4/20/36*, 19*36*

I last saw him alive on *4/20*, 19*36*. Death is said to have occurred on the date stated above, at *4:25* P.M.

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

*Pneumonia* Date of onset

Other contributory causes of importance: *Constitutes not Mumps*

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) *J.W. Morris*, M. D.

(Address) *City, Mo.*

