

OCT 15 1933

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

Do not use this space.

**1. PLACE OF DEATH**

County

Township

City

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

St.

Ward)

**2. FULL NAME**

(a) Residence, No.

(Usual place of abode)

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****4. COLOR OR RACE****5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word)**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF****6. DATE OF BIRTH (MONTH, DAY, AND YEAR)****7. AGE**

YEARS

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.****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)****13. NAME****14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)****15. MAIDEN NAME****16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)****17. INFORMANT (ADDRESS)****18. BURIAL, CREMATION, OR REMOVAL**

PLACE

DATE

**19. UNDERTAKER (ADDRESS)****20. FILED**

Registrar

**MEDICAL CERTIFICATE OF DEATH****21. DATE OF DEATH (MONTH, DAY, AND YEAR)****22. I HEREBY CERTIFY, That I attended deceased from**

, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. 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:

*Transverse Presenta  
 tion - brought to a  
 Breech.*

Date of onset

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)

\_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

33613

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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7  
33613  
Do not use this space.

1. PLACE OF DEATH

(a) County Bollinger Registration District No. 69  
(b) Township Filmere Primary Registration District No. 5105  
(c) City ..... (d) Street No. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Infant Garda

(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-22-1937

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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) Glen Allen (STATE OR COUNTRY) R. R. 1

13. NAME Charles Garda

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

15. MAIDEN NAME Maudie P. Randall

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

17. INFORMANT (ADDRESS) C. Galda  
Glen Allen Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Kinder Cem DATE June 26 1937

19. FUNERAL DIRECTOR (ADDRESS) Mr. Baker  
Witeville Mo

20. FILED Dec 9 1937 Mrs. J. A. Berry  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 26 1937

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... 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:

Transverse presentation  
brought to a breech

Other contributory causes of importance:

Stillbirth

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.....

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

If so, specify.....

(Signed) Adam J. Wagner, M. D.

(Address) Cravelton 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

