

NOV 18 1937

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)

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.

MEDICAL CERTIFICATE OF DEATH

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

19. UNDERTAKER (ADDRESS)

20. FILED

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

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

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

Date of onset

Perineal abscess;
in tuberculous
Ascending Pyelo-
nephritis / 33a

Other contributory causes of importance:

Terminal Broncho-
pneumonia

Name of operation

Date of

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

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. P. De Maria M. D.

(Address) Supt. 72 C Gen Hosp KC

Registrar.

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.

PLEASE RETURN TO THE
OFFICE OF THE DIRECTOR
OF THE BUREAU OF REVENUE
WASHINGTON, D. C.

RECEIVED BY THE
BUREAU OF REVENUE
WASHINGTON, D. C.

RECEIVED BY THE
BUREAU OF REVENUE
WASHINGTON, D. C.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

369224
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Primary Registration District No. 1002 Registered No. 4351
(c) City H. C. (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. (0) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME E. L. Hetzler

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
69 _____

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) (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) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 10/29 1937 M. M. Groves Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 23 1937

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said

I last saw h. alive on, 19... m. Death is said to have occurred on the date stated above, at

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

untraceable to secure your name

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) P. J. Demaria M. D.

(Address) Dept. Gen. Hosp. H. C. 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.

SUPPLEMENTARY

5-36922