

REC'D JUN 14 1938

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

18913
 Do not use this space.

1. PLACE OF DEATH

(a) County Moniteau Registration District No. 571
 (b) Township Walker Primary Registration District No. 6769 Registered No. 30
 (c) City _____ (d) Street No. _____ St. _____
 (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

John Kolb H30
 (a) Residence, No. Moniteau, 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-6-1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 1 8

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) Ohio

FATHER 13. NAME Jacob Kolb

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

MOTHER 15. MAIDEN NAME Elizabeth Girtner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Anna Kolb
Moniteau County

18. BURIAL, CREMATION, OR REMOVAL PLACE Reobash, Cemetery DATE May 16 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jack Bowlin,
California, Mo

20. FILED 5-17-38 A. R. Popejoy Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14th 1938

22. I HEREBY CERTIFY, That I attended deceased from May 17, 1938, to May 14, 1938

I last saw him alive on May 1st 1938. Death is said to have occurred on the date stated above, at 9 A.M.

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

Arterio sclerosis with valvular heart disease. Cause unknown.

Date of onset

Other contributory causes of importance:

Bronchitis following Influenza.

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? NO

If so, specify L. L. Sathum, M. D.

(Signed) California, Mo (Address) _____

504

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Earl R. Boulton

or by

Registered Apprentice No....., working under my personal supervision.

Signed

Earl R. Boulton

Licensed Embalmer No. *2126*

P. O. Address *California*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Moniteau Registration District No. 571
 (b) Township Walker Primary Registration District No. 5769
 (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. moa. ds.

2. PRINT FULL NAME John Hall

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14 1938

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 1 8

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

OCCUPATION
 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

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:
 Date of onset

FATHER
 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

MOTHER
 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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.

17. INFORMANT (ADDRESS)

Manner of injury.....
 Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....

19. FUNERAL DIRECTOR (ADDRESS)

(Signed) L. L. Latham, M. D.
 (Address) California

20. FILED 5-17-1938 H. P. Roberoy Local Registrar

SUPPLEMENTARY

THIS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Exact statement of OCCUPATION is very important.

