

330 JUN 13 1939

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

18008
Do not use this space.

1. PLACE OF DEATH *Boone* ?
(a) County *Columbia* 1
(b) Township
(c) City
(d) Street No. *73*
(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 B. ALTGILBERS*
(a) Residence, No. *702 N 7th St* 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 *Male*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widower*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary Lee Altgilbers*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 30 1859*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
79 9 10
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
Retired former

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*
13. NAME *Altgilbers*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*
15. MAIDEN NAME *Don't Know*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*
17. INFORMANT (ADDRESS) *Lena Altgilbers Columbia Mo*
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *Harrisburg Mo 5-13-39*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *P. Parker Columbia Mo*
20. FILED *5/13/39 Allie Selby Local Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-11-1939*
22. I HEREBY CERTIFY, That I attended deceased from *5-11-1939* to *5-11-1939*
I last saw him alive on *5-11-1939* Death is said to have occurred on the date stated above, at *11 P.M.*
The principal cause of death and related causes of importance were as follows:
Gangrene & Angiosclerosis Date of onset *8-2-39*
Other contributory causes of importance:
Bright's & Hardened Arteries Do not know.
Name of operation *None* Date of *None*
What test confirmed diagnosis? *None* Was there an autopsy? *No*
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *No* Date of injury *None*
Where did injury occur? *None* (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury *None*
Nature of injury *None*
24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify *W.P. Dysentery*
(Signed) *W.P. Dysentery* M. D.
(Address) *Columbia Mo*

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.

1322

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, ~~only~~.....

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

Signed

M. A. Whitesides

Licensed Embalmer No. *3893*

P. O. Address *Columbus, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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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18008
Do not use this space.

1. PLACE OF DEATH

(a) County Boone
(b) Township Columbia
(c) City Columbia

Registration District No. 73
Primary Registration District No. 3006

Registered No. 104

(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

(a) Residence, No. John B. Altgibbers St. ☐
(Usual place of abode, if no street address, write county or city) (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) Wid

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

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

7. AGE YEARS 79 MONTHS 9 DAYS 10 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) (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____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-11-1937

22. I HEREBY CERTIFY, That I attended deceased from 19____ to _____, 19____

I last saw him _____ 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:

Gastrectomy Angio Sclerotic Date of onset 121

Other contributory causes of importance:

Bright & Hardened Arteries
Chronic

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) W. P. Dyar _____, M. D.

(Address) Columbia mo

JUN 14 1939

MEMO

TO: THE CHIEF OF BUREAU OF INVESTIGATION

FROM:

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]