

FILED SEP 25 1940

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

Do not use this space.

1. PLACE OF DEATH

County St. Charles 2
Township Farmington 1
City 531 (No. Henry Guenther)

Registration District No. 755
Primary Registration District No. 5996a

File No. 29501
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 20 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 15 1868</u>		
7. AGE	YEARS	MONTHS
	<u>71</u>	<u>11</u>
		DAYS
		<u>24</u>
		IF LESS than 1 day,hrs. ormin.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Labourer</u>
	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) <u>Sept 1929</u>
	11. Total time (year) spent in this occupation <u>Life</u>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
St. Louis Mo

13. NAME
Louis Knorr

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Unknown 9

15. MAIDEN NAME
Louis Knorr

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Unknown 9

17. INFORMANT Wm Willenbrink
(ADDRESS) Augusta Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Cath Cemetery DATE May 11 1940

19. UNDERTAKER Shelby + Son
(ADDRESS)

20. FILED May 10 1940
Calvin Gray Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9 1940

22. I HEREBY CERTIFY, That I attended deceased from May 9 1940, to May 9 1940.
I last saw him alive on May 10 2P, 1940. 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:

Coronary Thrombosis Date of onset 5/10/40
94 1/2

Other contributory causes of importance:
Pepper-tussion 44 1/2
Arteriosclerosis 94 1/2

Name of operation None Date of _____
What test confirmed diagnosis? Stemcel Was there an autopsy? no

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.

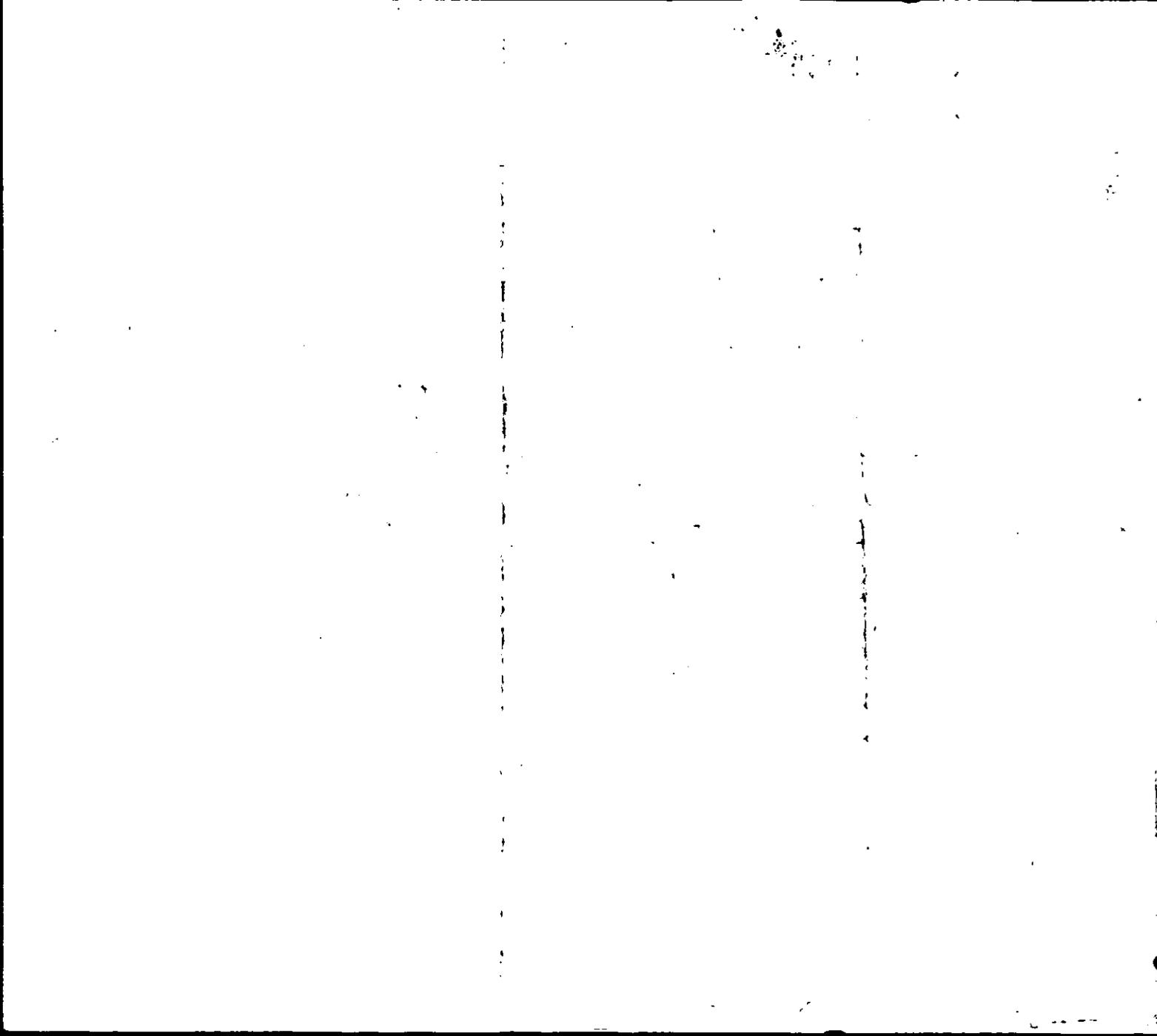
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Calvin Gray M. D.
(Address) Augusta 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

MARGIN RESERVED FOR BINDING



MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

State File No. **29501**

Registration District No. **755**

Primary Registration District No. **5996**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **St Charles**
 (b) City or town **St Charles**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Henry Guenther
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years **71** Months **11** Days **24** If less than one day _____ h. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St Charles**
 (c) City or town **Augusta (Rural)**
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? **Native** _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **9**
 year **1990** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **Calvin Clay** (M. D. or other) _____

Address **Augusta** No. _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

