NOV 21 1940

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

36076
Do not use this space.

20

1. PLACE OF DEATH

(a) County Platte — Registration District No. 696

(b) Township Fair -- — Primary Registration District No. 5925 — Registered No. 25

(c) City ~~Platte City, RFD.~~ (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 MATHEJ RENZ

(a) Residence, No. R. F. D. Platte City, Mo. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
Male	White	Widowed.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 31, 1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	78	6	13	

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. Farmer.

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) Weston, Missouri

FATHER

13. NAME Zacheus Renz

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

MOTHER

15. MAIDEN NAME Theresa Gramer.

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

17. INFORMANT Paul Renz.
(ADDRESS) Platte City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Platte City, Mo. DATE 10/16/40 19

19. FUNERAL DIRECTOR (NAME) L. F. Rollins.
(ADDRESS) Platte City, Mo.

20. FILED 10-17 1940 Mrs Frances E Murray
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/13/1940 9:40 P.19 M.

22. I HEREBY CERTIFY, That I attended deceased from October-9-, 1940 to Oct-13-, 1940

I last saw him alive on Oct-13-, 1940. Death is said to have occurred on the date stated above, at 9:40 p.m.

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

	Date of onset
Pneumonia (Hypostatic)	Oct-6-1940

Other contributory causes of importance:
Myelitis (unable to walk for approximately 3 months) & Cerebral Sclerosis

Name of operation None Date of

What test confirmed diagnosis? Clinical 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) Lewis C. Calvert, M. D.
(Address) Weston, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

1940

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, E. Benjamin Cast, [redacted]

[redacted], [redacted]

Signed E. Benjamin Cast

Licensed Embalmer No. 4059

P. O. Address Platte City, 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.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36076

Registration District No. 696 Primary Registration District No. 5925 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Platte

(b) ~~City or town~~ Fair Tip
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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.? years.

3. (a) PRINT FULL NAME John Matthew Renz

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 wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 78 Months 6 Days 13 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 13
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia (Hypostatic)

Due to Myelitis and Cerebral Sclerosis

Due to Cerebral arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) 10 7 W

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 (M. D. or other)
Address Date signed