PLACE OF DEATH

County: Cape Girardeau

Township: do

or Village:

or City: Cape Girardeau No. 39 N Burton St.; Ward)

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

33693

Registration District No. 125 File No.

Primary Registration District No. 3009 Registered No. 1442

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Walter Roth

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

DATE OF BIRTH: Oct. (Month) 1st (Day), 1916 (Year)

AGE: ____ yrs. ____ mos. 7 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Cape Girardeau Mo

PARENTS

NAME OF FATHER: Walter Roth

BIRTHPLACE OF FATHER (City or town, State or foreign country): St. Louis Mo

MAIDEN NAME OF MOTHER: Cora Koeppel

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Egypt Mills Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Walter Roth

(ADDRESS): 39 N Burton Cape Gir.

Filed: Oct 7, 1916. R. W. Greene, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: October (Month) 7 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 7, 1916, to Oct 7, 1916, that I last saw him alive on Oct 7, 1916, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

159 151

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G B Schultz M. D.

Oct 7th 1916 (Address) Cape Girardeau

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Fairmount Cemetery

DATE OF BURIAL: Oct 8, 1916

UNDERTAKER: Walther F. & U. Co.

ADDRESS: Cape Girardeau Mo

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. .... St.: ..... Ward)

(If death oc
hospital or
give its NA
of street and

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....
(Month) (Day)

I HEREBY CERTIFY, that I attended decea

....., 191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos.

Contributory.....
(SECONDARY)
.....(Duration).....yrs. .....mos.

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRA RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS