LOCAL REGISTRAR'S RECORD DO NOT TEAR LEAF OUT

16051

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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.

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

1. PLACE OF DEATH

...nty Gasconade

...nship Richland

...age

Registration District No. 304 File No. 173

Primary Registration District No. 5421 Registered No.

(NO. ... St.; ... Ward)

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

2 FULL NAME Henry Uffleman

PERSONAL AND STATISTICAL PARTICULARS

...le | 4 COLOR OR RACE White | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

...E OF BIRTH Mch (Month) 22 (Day) 1869 (Year)

51 yrs. 0 mos. 13 ds. If LESS than 1 day, ... hrs. or ... min.?

...CUPATION Trade, profession, or ...icular kind of work Laborer

General nature of industry ...ness, or establishment in ...h employed (or employer)

...THPLACE ...or town, ...or foreign country) Gasconade Co.

10 NAME OF FATHER Jno Uffelman

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

12 MAIDEN NAME OF MOTHER Don't Know

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

...E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

...formant) Mrs Hy Uffelman

(Address) Gasconade, Mo

...ed 4-9, 1920 F L Kicker Registrar

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr (Month) 6 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..., 1917, to Apr 6, 1920, that I last saw him alive on Apr 3, 1920, and that death occurred, on the date stated above, at 3300 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

28

23A (Duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) L H Caughill M. D.

4/6, 1920 (Address) Herman Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Gasconade | DATE OF BURIAL Apr 7, 1920

20 UNDERTAKER Pope & Engelage | ADDRESS Morrison Mo

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MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 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 occur hospital or inst give its NAME of street and nu

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

8 OCCUPATION

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

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

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

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 19

that I last saw h.....alive on ....., 19

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 Caus (1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 1

20 UNDERTAKER

ADDRESS