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

County Henry

Township ~~Clinton~~ or

Village Deepwater or

City (NO. St.; Ward)

Registration District No. 1851

Primary Registration District No. ~~4208~~ 4208

File No. 754

Registered No. 1

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

2 FULL NAME Agnus A. Erhart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: June (Month) 11 (Day) 1845 (Year)

7 AGE: 75 yrs. 11 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife 82
(b) General nature of industry business, or establishment in which employed (or employer) - 162

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

PARENTS

10 NAME OF FATHER Edward Lauck

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

12 MAIDEN NAME OF MOTHER Unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nora Erhart
(Address) Deepwater Mo

15 Filed 1-10, 1921 J. H. Krenell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 (Month) 8 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191...,
that I last saw h... alive on ....., 191...,
and that death occurred, on the date stated above, at Deepwater Mo

The CAUSE OF DEATH* was as follows: No Doctor in attendance, but seen two days after death, and Probable Cause was Apoplexy

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

CONTRIBUTORY (Secondary) Advanced age

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

(Signed) W. Kelly M. D.
1-8-, 1921 (Address) La Due 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 Deepwater Burial

DATE OF BURIAL 1-10, 1921

20 UNDERTAKER E R Hodges

ADDRESS Deepwater Mo

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

1 PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City ..... (NO. ....., ... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

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

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important.

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) ..... (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..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) ..... M. D.

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

*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	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS