LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

11580

1. PLACE OF DEATH
County Jasper — Registration District No. 411 — File No.
Township — Primary Registration District No. 2002 — Registered No. 160
City Joplin, Mo. (No. ... St. ... Ward)

2. FULL NAME Charles Wollgast
(a) Residence. No. 2001 Jackson St. ... Ward. ... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Mar.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lorene Wollgast
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 18 1856
7. AGE: Years 67 — Months 7 — Days 13 — If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Jeweler
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Iowa
PARENTS
10. NAME OF FATHER: Edward Bernhardt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Berlin, Germany
12. MAIDEN NAME OF MOTHER: Henrietta Ehrbrook
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
14. INFORMANT: Mrs. C. Wollgast (Address) 2001 Jackson Co.
15. FILED 4/1 1924 Benson Clark, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr. 1 1924
17. I HEREBY CERTIFY, That I attended deceased from Mch 20 — 1924, to Apr. 1 — 1924, that I last saw him alive on Mch 31 — 1924, and that death occurred, on the date stated above, at 12 30 p m.
THE CAUSE OF DEATH* WAS AS FOLLOWS: General Arteriosclerosis
49
(duration) Many yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY) ... (duration) ... yrs. ... mos. ... ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Ruth L. Neff, M. D.
4/2 1924 (Address) Joplin Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mount Hope Cem. — DATE OF BURIAL: April 4 1924
20. UNDERTAKER: Frank-Sievers Co. — ADDRESS: Joplin Mo.

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

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

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

City..... (No..... .....St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

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

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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