

MAY 29 1928

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

Do not use this space.

12554

1. PLACE OF DEATH

County Cass
Township Charleston
City Charleston (No.)

Registration District No. 135
Primary Registration District No. 3010

File No.
Registered No. 42 (Word)

2. FULL NAME Charles Dehler

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-5-1928

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

17. I HEREBY CERTIFY, That I attended deceased from March 12th 1928, to April 5th 1928 that I last saw h. l. m. alive on 4-10-1928 and that death occurred, on the date stated above, at 10 P.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-6-1867

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sarcoma of Kidney

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
60 | 7 | 29 |

CONTRIBUTORY (SECONDARY) 49 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? yes DATE OF 3-4/28
WAS THERE AN AUTOPSY? no

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

10. NAME OF FATHER John Dehler

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

12. MAIDEN NAME OF MOTHER Rena Meeder

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. B. Stone, M. D.
, 19 (Address)

14. INFORMANT Jacob Dehler
(Address) J. Miami Station 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.

15. FILED 4-5-1928 ma E. E. Farnham REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Evergreen Cemetery New York 4-8-1928
20. UNDERTAKER ADDRESS
Willis Brubaker Charleston Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Walter P. ...

Carroll ...

ST. LOUIS, MO. 63101

... ..

... ..

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carroll Registration District No. 133- File No.
 Township Primary Registration District No. 3010 Registered No. 42
 City Carrollton (No.) St. Ward)

2. FULL NAME

Charles Dekker
 (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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-5-1928

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

17. I HEREBY CERTIFY That I attended deceased from 19....., 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:

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
 (c) Name of employer

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

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.

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) 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

15. FILED 4-5-28 me & E Fernham 20. UNDERTAKER ADDRESS

N. B.—Every item of information furnished on this form should be stated in plain terms, so that it may be properly classified. Exact statements of cause of death in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

REGISTRAR

S-12554