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

Do not use this space.

7727

1. PLACE OF DEATH
County: St Charles — Registration District No.: 757 — File No.:
Township: — Primary Registration District No.: 3036 — Registered No.: 36
City: St Charles (No. St Joseph Hospital St. Ward)

2. FULL NAME: Clever Joseph Commeyer
(a) Residence. No. St., Ward. Portage des Sioux Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred – yrs. – mos. 2 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*): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Ina

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 18-1885

7. AGE: Years 43 | Months 11 | Days 8 | If LESS than 1 day, ___ hrs. or ___ min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Portage des Sioux Mo

PARENTS
10. NAME OF FATHER: Joseph Commeyer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St Charles Mo.
12. MAIDEN NAME OF MOTHER: Lena Boschert
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St Charles Mo

14. INFORMANT: John Commeyer
(Address) Portage des Sioux

15. FILED: 7-27, 1929 Fay G. Blostum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 26 1929

17. I HEREBY CERTIFY, That I attended deceased from ~~June 1~~, 19..., to ~~July 26~~, 19..., that I last saw him alive on ~~July 26~~, 192~, and that death occurred, on the date stated above, at 6:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental due to being struck by an automobile
210 M (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? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) Fleming Crowe, M. D
2-24, 1929 (Address) St Charles 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Francis Cemetery — DATE OF BURIAL: Mar 1 1929

20. UNDERTAKER: H. Dallmeyer & Son — ADDRESS: St Charles Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Charles — Registration District No. 757 — File No. .....

Township ..... — Primary Registration District No. 3036 — Registered No. 36

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

2. FULL NAME Oliver Joseph Connayer

(a) Residence. No. ..... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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 2/27, 1929 Hy. G. Blackburn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 26 1929

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:
accidental due to being struck by an automobile about 7 miles north of the City of St. Charles, St. Charles County
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 200
(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.

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

SUPPLEMENTARY

S-7727