

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

Do not use this space.

1-9819
File No. _____
Registered No. 65 _____
St. _____ (Ward)

24 1929

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 125
Township Cape Girardeau Primary Registration District No. 3009
City Cape Girardeau No. Lo & Mo. Hospital

2. FULL NAME Hubert Demoro Christoph

(a) Residence No. Fredericktown Mo. St. Ward _____
(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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16, 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>74</u>	<u>4</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Druggist
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Maxamillian Christoph

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Marie Demoro

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

14. INFORMANT Mrs. Fannie Christoph
(Address)

15. FILED 3/1 29 W. Kaempfer
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/3- 19 29

17. I HEREBY CERTIFY That I attended deceased from 1/10, 1929, that I last saw him alive on 3/3, 1929 and that death occurred, on the date stated above, at 1145 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio Sclerosis
Paralysis Paralytica
(duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Smoking
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Heart by microscope
(Signed) [Signature] M. D.
, 19 (Address) Cape Girardeau 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 Fredericktown DATE OF BURIAL 3/8 19 29

20. UNDERTAKER Falther Undertaking Co. ADDRESS Cape Girardeau Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. *One amount of state or county supplied. # 6 all day diff 161 3 31 16

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CERTIFICATE OF DEATH**

1817
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

Connty. Cape Girardeau Registration District No. 125- File No.
Township Primary Registration District No. 3009 Registered No. 65-
City (No.) St. Ward)

2. FULL NAME Hubert D. Christoph

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16 - 1854
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 4 17

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)

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 5/20, 19 29 W. K. Kumpfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/8 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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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.

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

20. UNDERTAKER
Walther Und. Co. Cape Gir. Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

any important. (in p.l.s. terms, so that it properly classifi.

5-9819