

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

Do not use this space.

13587

1. PLACE OF DEATH
 County: Texas Registration District No. 1171
 Township: Jackson Primary Registration District No. 6145
 City: _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME Milton Henry Diedrich
 (a) Residence No. _____ St. _____ Ward. Raymondville, Mo
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? 67 yrs. 4 mos. 5 da.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IS MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Diedrich
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2 1861
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
67 4 5

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) I
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo Henry Co
 (STATE OR COUNTRY) Ill

10. NAME OF FATHER Milton Henry Diedrich
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) U. S.
 12. MAIDEN NAME OF MOTHER Elizabeth Ray
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) England

14. INFORMANT Mrs. Alice Purebell
 (Address) Raymondville Mo

15. FILED 3/7 1929 Mrs. John S. Holt
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 7 1929
 17. I HEREBY CERTIFY That I attended deceased from Feb. 13
 _____, 1929, that I last saw h. AAA, alive on Feb. 13, 1929, and that death occurred, on the date stated above, at 2 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
can
prob
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) HTA
 (duration) _____ yrs. _____ mos. _____ da.

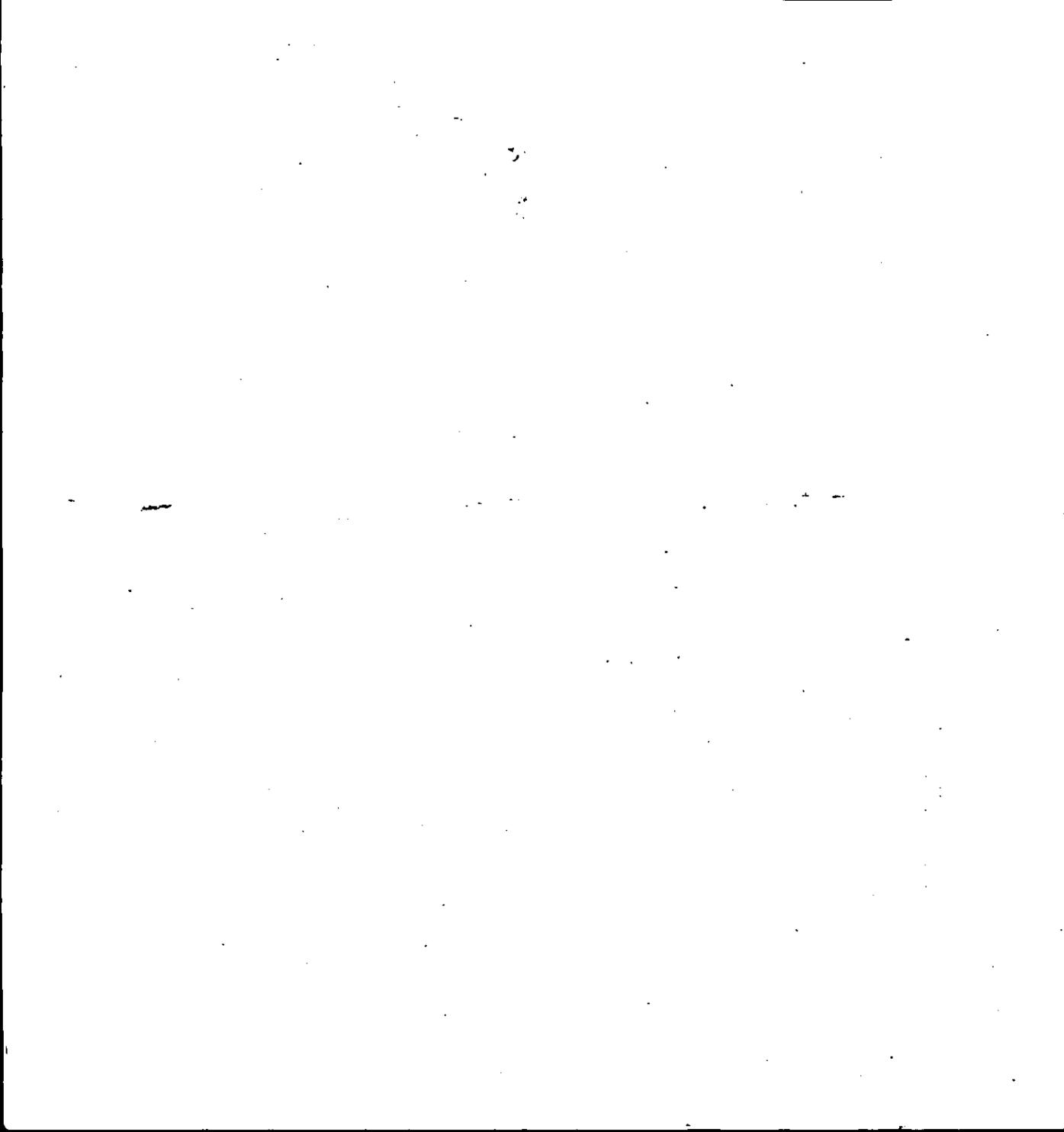
18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS, _____
 (Signed) N. P. Herron, M. D.
Mar. 7, 1929 (Address) Houston, 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 Allen Cemetery Raymondville Mo DATE OF BURIAL 1929

20. UNDERTAKER Mo ADDRESS _____

1
2
2
8



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 1171 File No.
 Township Jackson Primary Registration District No. 6143- Registered No.
 City (No.) St. Ward)

2. FULL NAME

Milton Henry Diedrich

(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 m
(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)

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 3/7, 1929 Mrs. J.S. Holt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1929

17. I HEREBY CERTIFY That I attended deceased from 19... to 19... that I last saw him 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

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

20. UNDERTAKER Wm McColgin ADDRESS Raymondville Mo

SUPPLEMENTARY

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

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