APR 24 1929

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

Do not use this space.

14384

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 303
City Springfield — Springfield Hosp. St. ... Ward)

2. FULL NAME John Beierle
(a) Residence. No. Crocker Mo 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: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 21 1888

7. AGE: 40 YEARS — MONTHS: 10 — DAYS: 15 — 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): Mo

PARENTS
10. NAME OF FATHER: John Beierle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): German
12. MAIDEN NAME OF MOTHER: Wagoner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Annie Owen
(Address) R# 8

15. FILED 4-8, 1929 Lon Sharp REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 6 1929

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to April 6, 1929, that I last saw him alive on April 5, 1929, and that death occurred, on the date stated above, at 12:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Meningitis.
9 in
(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (SECONDARY) Tuberculous Spine.
(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? ✓
WHAT TEST-CONFIRMED DIAGNOSIS? X-ray & Lab
(Signed) Robert Glynn M. D
4/7, 1929 (Address) Springfield 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: National Cem.
DATE OF BURIAL: 4/8/ 1929

20. UNDERTAKER: Lohmeyer
ADDRESS: Springfield

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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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