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

Do not use this space.

531

File No. .....

Registered No. 10

1. PLACE OF DEATH

County Clay — Registration District No. 198

Township Fishing River — Primary Registration District No. 3011

City Excelsior Springs Mo. (No. Elms Hotel St. ..... Ward)

2. FULL NAME James C. Dahlman

(a) Residence. No. Elms Hotel St., ... Ward. Omaha Nebr.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 - 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73	1	6	

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

9. BIRTHPLACE (CITY OR TOWN) York Town
(STATE OR COUNTRY) Texas

PARENTS

10. NAME OF FATHER Charles Dahlman

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

12. MAIDEN NAME OF MOTHER Mary. —

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

14. INFORMANT Harriett Dahlman
(Address) Omaha Neb

15. FILED 1/22 1930 Y. D. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 21st 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20th, 1930, to Jan. 21st 1930, that I last saw him alive on Jan. 21st 1930, and that death occurred, on the date stated above, at 11 20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy.

82 hr (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

many years (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? Clinical
(Signed) E. L. Rothrock, M. D.
1/22 1930 (Address) Excelsior Springs, 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	DATE OF BURIAL
Omaha Neb	Jan 25 1930
20. UNDERTAKER John C Prather	ADDRESS Ex Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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