

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

Do not use this space.

4092

1. PLACE OF DEATH

County Buchanan. Registration District No. 85
 Township..... Primary Registration District No. 1001
 City St. Joseph (No. St Joseph Hospital) St. _____ Ward _____

File No. _____
 Registered No. 159
 St. _____ Ward _____

2. FULL NAME Rev. Chas. Waechter

(a) Residence. No. _____ St. _____ Ward. Conception Missouri
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 4, 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
45 1 1

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Clyde
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER John F Waechter

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

12. MAIDEN NAME OF MOTHER Sophia Juiene

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

14. INFORMANT Mrs. Katherine Tracey
 (Address) St Joseph Missouri

15. FILED 1930 John E. J. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 5 1930

I HEREBY CERTIFY, That I attended deceased from Jan 30 to Feb 5 1930
 that I last saw him alive on Feb 5, 1930, and that death occurred, on the date stated above, at 3/55 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tub. Tbc.
1314

CONTRIBUTORY (SECONDARY)

Bron. asthma (duration) 4 yrs. mos. ds.
3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT A PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Monte Hankins M. D.
Feb 5, 1930. (Address) Timpanua Blg

*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

Conception Mo.

DATE OF BURIAL

Febr. 6 1930

20. UNDERTAKER

H.C. Siddeford

ADDRESS

1802 Union St.

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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