

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

Do not use this space.

5008

1. PLACE OF DEATH

County Jackson
Township New
City Keokuk

Registration District No. 399

Primary Registration District No. 1007

File No. 305
Registered No. 305
St. Summit Ward

2. FULL NAME

(a) Residence. No. 1647 Summit Ward.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb - 10 1930

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

17. I HEREBY CERTIFY, That I attended deceased from 10/19, 1929, to 2-10, 1930 that I last saw h. in alive on 1-20, 1929, and that death occurred, on the date stated above, at 2:38 0 m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 21 1871

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pericarditis

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 2 29

(duration) yrs. 4 mos. ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
(duration) yrs. mos. ds. 2

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. yes

10. NAME OF FATHER Wm L. Dobell

DID AN OPERATION PRECEDE DEATH? no DATE OF no

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wash Hill

12. MAIDEN NAME OF MOTHER Alvra Haubold.

WHAT TEST CONFIRMED DIAGNOSIS? Physioid signs
of cholera
(Signed) J. H. Holbrook, M. D.

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

7/11, 1930 (Address) 737 Liberty Bell

14. INFORMANT Berrie Dobell
(Address) 1647 Summit

*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.

15. FILED 2/13 30 M. M. Brown
REGISTRAR Asst

20. UNDERTAKER Wash Hill DATE OF BURIAL 2/13 30

ADDRESS 1915 East 13

This statement of OCCUPATION is very important. Do not use this space. Do not use this space.

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W. L. HOLLISTER, M. D.

OFFICE, 736-737 LATHROP BLDG.

PHONE VICTOR 9628

HOURS: 3 TO 6 P. M.

KANSAS CITY, MO.

RES. 2614 E. 9TH ST.

PHONE BENTON 3199

R

Reference to the original
death certificate will show
that this man died of Peri-
carditis. In the supplementary
report herewith it has become
peritonitis apparently by error.
We think that page 6 paragraph
8.7 explains this. If further
information is needed please let
us know

NON REPETATUR
NON COPIA

BY

W. L. Hollister

M. D.

U. S. REG. NO. 1159

S-5008 (2)

1930

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County

Registration District No. 399

File No.

Township

Primary Registration District No. 1002

Registered No. 665-

City R. City (No.)

St. Ward)

2. FULL NAME Wm. Dobell

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

m

5A. IS 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 7/13 19 30

M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/10 19 30

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on, 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastritis Acute (Pericarditis)

CONTRIBUTORY (SECONDARY)

Indigestion

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) P. L. Schleyer, M. D.

, 19 (Address) 736 Lathrop Bldg

*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

ADDRESS

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

PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION is very important.

S-5008 (2)

1930