

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

Do not use this space.

11433

1. PLACE OF DEATH

County Texas Co
Township Cornell
City Summit (No. _____)

Registration District No. 867 1077
Primary Registration District No. 6140

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME Bess Zehr

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 1865

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, <u>6</u> hrs. or <u> </u> min.
<u>64</u>	<u>64</u>	<u>2</u>	<u>27</u>	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nearby (Crogan)

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER Bert Kow

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

14. INFORMANT J. B. Zehr
(Address) Summit Mo

15. FILED 8.22, 1930 L.H. Walker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-9 1930, to 3-14 1930, that I last saw her alive on our 3-13, 1930, and that death occurred, on the date stated above, at 5:2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart disease
95B
(duration) 2 yrs. 6 mos. 2 ds.

CONTRIBUTORY (SECONDARY) None
(duration) 0 yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Dr L.H. Walker M. D.
, 19 (Address) Summit 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 Grundy Mo DATE OF BURIAL 3-16 1930

20. UNDERTAKER James Kutman ADDRESS Grundy

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.

PR 30 1930

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