

NOV 21 1930

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

Do not use this space.

32002

1. PLACE OF DEATH

County *Andrew*

Registration District No. *13*

File No. _____

Township *Savannah*

Primary Registration District No. *4070*

Registered No. *45*

City *Savannah* (No. _____)

St. _____ Ward _____

2. FULL NAME

Nathan J. Mullerix

(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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 11 - 1839*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
90 11 0

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

9. BIRTHPLACE (CITY OR TOWN) *un known*
(STATE OR COUNTRY) *Ill.*

10. NAME OF FATHER *Nathaniel Mullerix*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *un known*
(STATE OR COUNTRY) *un known*

12. MAIDEN NAME OF MOTHER *Sarah*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *un known*
(STATE OR COUNTRY) *un known*

14. INFORMANT *Mr Amanda Smith*
(Address) *Savannah*

15. FILED *Oct 13 1930* REGISTRAR *C. J. Jones md*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 11 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 10*, 19*30*, to *Oct 11*, 19*30* that I last saw him alive on *Oct 10*, 19*30*, and that death occurred, on the date stated above, at *9:15 AM*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Embolism
GHA
SVD

CONTRIBUTORY (SECONDARY) *Angina Pectoris*
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IN NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

19. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *physical*
(Signed) *Walter D. Myers*, M. D.
(Address) *Savannah*

*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 *Savannah* DATE OF BURIAL *10-13 1930*

20. UNDERTAKER *R. L. Breit Savannah*
ADDRESS *Mo*

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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