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

Do not use this space.

743

FEB 18 1931

1. PLACE OF DEATH
County: Dent
Township: Watkins
City: ..... (No. ..... St. ..... Ward)
Registration District No. 266
Primary Registration District No. 3-378
File No. .....
Registered No. 3

2. FULL NAME: John Adolphus Betz

(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~~: Mrs J A Betz

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 30 1860

7. AGE: Years 70 | Months 3 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Quincy Ill
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: Christian Betz
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): France

14. INFORMANT: Mrs J A Betz
(Address): Licona Mo

15. FILED 1/21, 1931 H. E. Rudd, Co. Clk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 19 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1931, to Jan 19, 1931, that I last saw ~~him/her~~ alive on Jan 19, 1931, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Probably cerebral hemorrhage (Was passing out on my arrival

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY): Don't Know

(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? None
(Signed) S. L. Mitchell, M. D
, 19 (Address) Rolla 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: x Lake Springs Mo
DATE OF BURIAL: 1-20 1931

20. UNDERTAKER: None
ADDRESS: x

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.