

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.

APR 20 1931

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

Do not use this space.

8662

1. PLACE OF DEATH

County Andrew, Registration District No. 8
 Township Lincoln, Primary Registration District No. 3011
 City (No. 2 1/2 Miles N.W. Amazonia, Mo.) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME Jacob Bechter,

(a) Residence. No. 2 1/2 M. N. W. Amazonia, Mo. St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married,</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Bechter,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 13, 1851

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>	<u>3</u>	<u>15</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Farmer, 1
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer Self,

9. BIRTHPLACE (CITY OR TOWN) Unknown,
 (STATE OR COUNTRY) Germany, 10

PARENTS	10. NAME OF FATHER <u>Joseph Bechter,</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Germany,</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown,</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Germany,</u>

14. INFORMANT Mrs. Jacob Bechter
 (Address) R.F.D.# 1, Amazonia, Mo.

15. FILED Mar 29, 1931 J. W. Holcomb
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 28, 1931

17. HEREBY CERTIFY, That I attended deceased from Jan 6, 1931 to Mar 28, 1931
 that I last saw him alive on Jan 25, 1931, and that death occurred, on the date stated above, at 3:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis

820
 (duration) _____ yrs. 4 mos. ds.
 CONTRIBUTORY (SECONDARY) 82.19
 (duration) _____ yrs. _____ mos. ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) S. S. Hewer, M. D.
 , 19 _____ (Address) Amazonia 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 <u>St. John's Rformed Cem.</u>	DATE OF BURIAL <u>Mc Mar 30 1931</u>
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20. UNDERTAKER <u>J. A. Bowman</u>	ADDRESS <u>Savannah, Mo.</u>
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