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

1872

PLACE OF DEATH

County Morgan — Registration District No. 601 — File No. 1

Township Richland — Primary Registration District No. 5796 — Registered No. 1

City ..... (No. ..... St. ..... Ward)

FULL NAME Caleb Henry Cramer

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

th 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

EX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
ale	white	married

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) ~~WIFE OF~~ Nannie Cramer

ATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 5th 1847

GE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	84	2	11	

CCUPATION 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 [redacted]

IRTHPLACE (CITY OR TOWN) Florence
(STATE OR COUNTRY) Morgan Co., Mo.

10. NAME OF FATHER John Cramer

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

12. MAIDEN NAME OF MOTHER Sarah Blazegin

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

INFORMANT Ben Cramer
(Address) Sedalia, Mo

FILED 20 Jan 1932 Mrs Edwin Bremer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-16-32

17. I HEREBY CERTIFY, That I attended deceased from 1-8-32, 19..., to 1-16-32, 19..., that I last saw him alive on 1-16-32, 19..., and that death occurred, on the date stated above, at 10.45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
11 B
11 2 (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY) Frail Debility (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? No

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) E. E. Holtzen M. D.

1/16/32 19 (Address) Smithton 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bethelehem, Florence Mo.	1-18 1932

20. UNDERTAKER	ADDRESS
A. F. Neumeyer	Smithton Mo.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

E. E. Holtzen

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....W

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF 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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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I HEREBY CERTIFY, That I attended deceased from .....
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that I last saw h..... alive on.....,19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....

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).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

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