

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

NOV 23 1937

38575

1. PLACE OF DEATH

County Kandolph Registration District No. 735
 Township Moberly Primary Registration District No. 3094
 City Moberly (No. Wabash Hospital) St. Mo. Ward 225

2. FULL NAME

Frank Docekal
 (a) Residence, No. 1017 Simrock St. Mo. Ward 225
 (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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9th, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1937, to Oct 9, 1937.
 I last saw h./her alive on Oct 9, 1937. Death is said to have occurred on the date stated above, at 11 a.m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 5th 1859

The principal cause of death and related causes of importance were as follows:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>77</u>	<u>77</u>	<u>10</u>	<u>4</u>	

Chronic myocarditis Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation.

Chronic myocarditis
auricular fibrillation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

Other contributory causes of importance:
auricular fibrillation

13. NAME No data

Name of operation _____ Date of _____
 What test confirmed diagnosis? C. & Lab. Was there an autopsy? No

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

15. MAIDEN NAME "

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

17. INFORMANT (ADDRESS) Mrs Phil Skinner Moberly Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly DATE Oct 11th 1937

19. UNDERTAKER (ADDRESS) M. A. Brown and Son Moberly Mo

20. FILED Oct 11th 1937 Wabash Hospital Registrar.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Max E. Kases, M. D.
 (Address) Wabash Employees Hospital Moberly, Mo.

