LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

[stamp] ...R 26 1928

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

10273

V. S. No. 2.

1. PLACE OF DEATH

County Ray Registration District No. 744 File No.

Township Richmond Primary Registration District No. 5976 B Registered No. 28

City (No. St. Ward)

2. FULL NAME John J. C. Zirfacks

(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	MEDICAL CERTIFICATE OF DEATH
SEX: Male · 4. COLOR OR RACE: White · 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower	16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-18 1928
If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louise Zirfacks	17. I HEREBY CERTIFY, That I attended deceased from 1-15, 1928, to 3-18 1928 that I last saw him alive on 3-9 1928 and that death occurred, on the date stated above, at 7 A. m.
DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 4- 1847	THE CAUSE OF DEATH* WAS AS FOLLOWS: Mitral Regurgitation
AGE: YEARS 80 · MONTHS 11 · DAYS 15 · If LESS than 1 day, ... hrs. or ... min.	131 ... (duration) 5 yrs. mos. ds.
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	CONTRIBUTORY (SECONDARY) Chronic Nephritis (duration) yrs. mos. ds.
BIRTHPLACE (CITY OR TOWN) Witten Burg (STATE OR COUNTRY) Germany	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
10. NAME OF FATHER Henry J Zirfacks	DID AN OPERATION PRECEDE DEATH? No DATE OF
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany (STATE OR COUNTRY)	WAS THERE AN AUTOPSY? no
12. MAIDEN NAME OF MOTHER Sophia Wich	WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis (Signed) Hy. J. Hoare, M. D
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany (STATE OR COUNTRY)	3-20, 1928 (Address) Richmond Mo
INFORMANT Lew J Zirfacks (Address) Rayville 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.)
FILED Apr 6 1928 R L Hamilton REGISTRAR	19. PLACE OF BURIAL, CREMATION, OR REMOVAL McGaugh Cemetery · DATE OF BURIAL 3/19 1928 · 20. UNDERTAKER F S Rowland · ADDRESS Rayville Mo.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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

1. PLACE OF DEATH

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

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

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

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. ds.

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

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

17.

I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and th
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)....., M

, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 2.