

RETURNEDSTATE OF OHIO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Coshocton Registration District No. 243 File No. 1571151
Township Crawford Primary Registration District No. 4365 Registered No. 15
or Village No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ernest C. Valtz
(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

SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Widowed

If married, widowed or divorced

HUSBAND of (or) WIFE of

HusbandDATE OF BIRTH (month, day, and year) 11-19-49

AGE Years Months Days If LESS than 1 day ____ hrs. or ____ min.
70 10 14

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

M.D. Physician
3

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)

(State or country) Germany10 NAME OF FATHER Carl O. Valtz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Margrite Behring

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) GermanyInformant Chas. Valtz(Address) Cresno P. Rt 4Filed Sept 30 1950 W.D. Lowery

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 9-27 1920

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him _____ alive on _____, 19____,

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer

18 Did not call any Physician
(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)

(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?

(Signed) W.D. Lowery T.P. Clerk9-24, 1920 (Address) Belle O

*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, CEMETERY, OR _____ DATE OF BURIAL

Halifax Cem. 9-29 1920

20 UNDERTAKER, License No.

C. W. Leibell Cresno O.