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.

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

PLACE OF DEATH

County: Scott

Township: Moreland

or Village:

or City: (NO. , St.; Ward)

Registration District No. 814 File No. 3709

Primary Registration District No. 6068 Registered No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Mathias Schlosser

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Wht

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed.

DATE OF BIRTH: Feb. (Month) 26 (Day), 1827 (Year)

AGE: 83 yrs. 8 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): 5-01

BIRTHPLACE (City or town, State or foreign country): Died Kirchen Germany

PARENTS
NAME OF FATHER: — — — —
BIRTHPLACE OF FATHER (City or town, State or foreign country): — — —
MAIDEN NAME OF MOTHER: — — —
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Limburg Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Ewald J Schinder

(ADDRESS): New Hamburg

Filed Jan. 9, 1912. E. J. Wade REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec. (Month) 5 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 3, 1911, to Dec 4, 1911, that I last saw him alive on Dec 4, 1911, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Senility

15 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Ewald J. Schinder M. D.

Dec 6, 1911 (Address) New Hamburg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: New Hamburg, Mo

DATE OF BURIAL: Dec. 7, 1911

UNDERTAKER: Alex Dunbar

ADDRESS: New Hamburg Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

MISSOURI STATE BOARD (
BUREAU OF VITAL STAT
CERTIFICATE OF DEAT

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO.....,.....St.:.....Ward)

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

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day), 1.....(Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or.....min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....,

REGISTRAR

MEDICAL CERTIFICATE OF DEAT

DATE OF DEATH

.....(Month)

I HEREBY CERTIFY, that I attend

....., 191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated ab

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or Hor

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTION RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE
UNDERTAKER	ADDRE