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.

PLACE OF DEATH

County Cape Gir

Township ——

or Village ~~Cape~~

or City Cape Gir (No. 531 S Ellis St.; 3 Ward)

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

Registration District No. 125 File No. 15475

Primary Registration District No. 3009 Registered No. 1167

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

FULL NAME Johanna Schlimme

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

DATE OF BIRTH: Feb 16 (Month) (Day), 1851 (Year)

AGE: 64 yrs. 2 mos. 13 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): "

BIRTHPLACE (City or town, State or foreign country): Cape Co

PARENTS
NAME OF FATHER: Henry Sander
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Louise Muckey
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Tuschhoff

(ADDRESS) Cape Girardeau

Filed May 1, 1915 Geo E. Chappell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April 29 (Month) Thursday (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 28, 1915, to April 29, 1915, that I last saw her alive on April 27, 1915, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatus
131 Nephritis

about 1 yrs. 0 mos. 0 ds. (Duration)

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

(Signed) W. A. Schoen M. D.

Apr. 30, 1915 (Address) Cape Girardeau Mo.

*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: Fermont

DATE OF BURIAL: May 2, 1915

UNDERTAKER: M G Lorberg

ADDRESS: Cape Gir

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 import

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

PLACE OF DEATH

County.....

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

or

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

or

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

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., *1*.....
(Month) (Day) (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 DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

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

*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	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS