

MAR 16 1928

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

Do not use this space.

4166

1. PLACE OF DEATH

County Buohannan
Township.....
City St. Joseph.

Registration District No. 85
Primary Registration District No. 1001
(No. 2807 Ashland Avenue.

File No.
Registered No. 264
St. Ward)

2. FULL NAME

Alice Schmidt.

(a) Residence. No. 2807 Ashland Avenue. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed.

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

George Schmidt.6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 8, 1854.

7. AGE

YEARS

73

MONTHS

4

DAYS

21

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.(b) General nature of industry, business, or establishment in which employed (or employer).....
95B
94B
97

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Geneva
(STATE OR COUNTRY) Switzerland.10. NAME OF FATHER Unknown.11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown.
(STATE OR COUNTRY) Unknown.12. MAIDEN NAME OF MOTHER Unknown.13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown.
(STATE OR COUNTRY) Unknown.

14.

INFORMANT Mrs. B.F. Klippel.
Address 2807 Ashland Ave.

15.

FILED 1928John J. [Signature]

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 29 19 28

17.

I HEREBY CERTIFY That I attended deceased from Feb 28 1928, to Feb 29 1928 (that I last saw h. or alive on Feb 28 1928, and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart disease (arteriosclerosis)
coronary arteriosclerosis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no. DATE OF.....WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? urinal
(Signed) [Signature], M. D.3/1/1928 (Address) 1212 Olive St. Joseph, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Joseph Memorial Park CemMarch 3 1928

20. UNDERTAKER

ADDRESS

H. O. Sidungrader1802 Union St.

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.

hypertension and slight enlargement of the heart. There were no murmurs or evidence of any valvular disease. Suddenly her blood pressure dropped to a shock level and she had persistent and continuous severe pain in the heart region radiating to the left shoulder and down the arm. She lingered along for a few days and died. These findings are specific for one thing it would seem to me and that would be according to "Massachusetts General Hospital Nomenclature".:

Heart disease (arterio sclerotic)

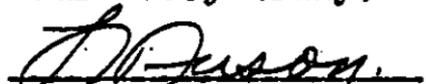
Arterio sclerosis general.

Coronary occlusion.

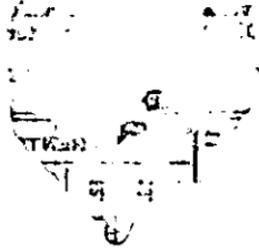
The immediate cause of death , "coronary occlusion".

You can see from my letter that it is not possible to fit this case into the classification suggested by your appended note.

Yours very truly,


Dr. L. H. Fuson

Handwritten text at the top left, possibly a header or address, including the words "Lob" and "Handwritten".



Handwritten text in the lower right quadrant, consisting of the number "5" followed by a circled "4" and the number "66", likely a date or reference number.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Buchanan Registration District No. 85 File No. _____
 Township St. Joseph Primary Registration District No. 1.001 Registered No. 264
 City St. Joseph (No. _____) St. _____ Ward _____

2. FULL NAME Alice Schmidt
 (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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W.

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) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-29 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____, 19____, and that death occurred, on the date stated above, at _____m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart Disease
ARTERIOSCLEROSIS and coronary
occlusion
 (duration) _____ 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? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) D. Pearson, M. D.
 , 19 (Address) Kit. Bldg. St. Joseph 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

15. FILED 5-23 19. 28 John H. W. REGISTRAR

SUPPLEMENTARY

FACTS. PHYSICIANS should sta. t of OCCUPATION is very important. AGE & SEX should be caref rns, so that it ma. CEIVE A FEE FOI REGIST

m

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101

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