

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 5-2-2 File No. 13671
 Township Franklin Primary Registration District No. 1-1-1 Registered No. 13671
 City Manchester St. Joseph Ward

2. FULL NAME

(a) Residence. No. 79 1/2 Blue Ridge Road (If nonresident give city or town and State)
 (Usual place of abode)
 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 8 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
29 4 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) MO

10. NAME OF FATHER Newton Schmitt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis MO

12. MAIDEN NAME OF MOTHER Lena Schmitt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis MO

14. INFORMANT (Address) John W. Shaw 79 1/2 Blue Ridge Road

15. FILED 19 1938 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 8 1938

17. I HEREBY CERTIFY That I attended deceased from 4-8, 1938, to 4-8, 1938, and that I last saw her alive on 4-8 of 1938, and that death occurred, on the date stated above, at St. Joseph, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Absence of brain + membranes

CONTRIBUTORY (SECONDARY) Influenza (duration) yrs. mos. ds. 1

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? Physical signs

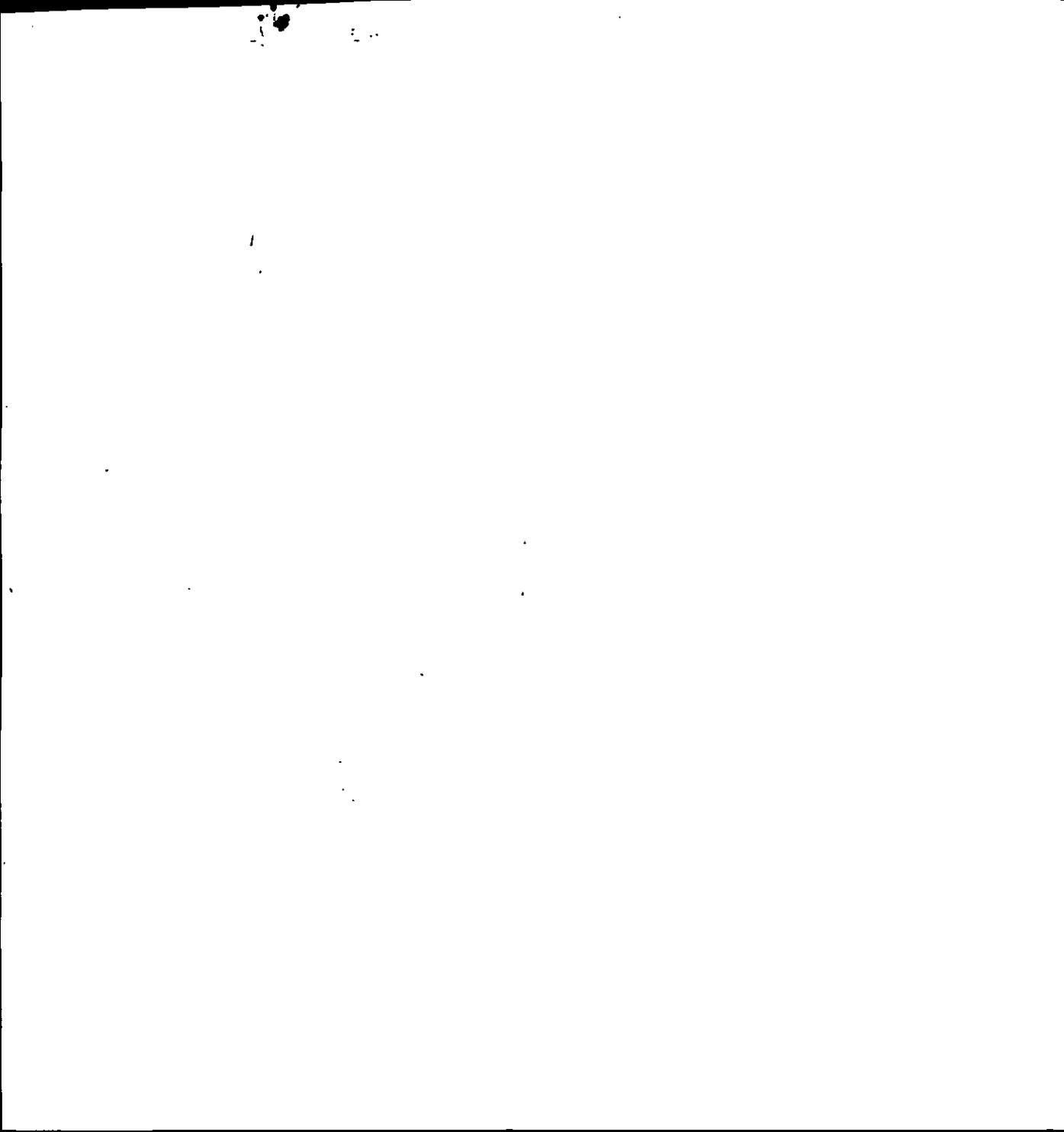
(Signed) W. W. Hobb, M. D.

St. Louis, 1938 (Address) Newton 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 Burial DATE OF BURIAL 4/10 1938

20. UNDERTAKER W. W. Hobb ADDRESS 145 East 15th



OFFICE HOURS
1 TO 3 P. M.
SUNDAY BY APPOINTMENT

TELEPHONE LEEDS 1103

DR. W. W. HOBBS
RAYTOWN, MISSOURI

This Brain Abscess
was not caused by
either Tuberculosis or
Traumatism. It followed
an Influenza infection.
Four days duration.

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16 981-5

**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 Jackson Registration District No. 203 File No.
 Township Brookline Primary Registration District No. 3557 Registered No.
 City (No.) St. Ward)

2. FULL NAME Louisa Edna Shaw
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 (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)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 4-8 1928 W. W. Hobbs REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-8-1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19....., and that I last saw him alone on 19....., and that death occurred, on the date above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:
abscess of brain and meningitis -
24 to 36 hours
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Influenza -
 (duration) yrs. mos. da.

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) W. W. Hobbs M. D.
4/8 1928 (Address) Reynolds, 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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE UNLESS CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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