

26 1928

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

Do not use this space.

30337

X

1. PLACE OF DEATH

County Howell Registration District No. 3824
Township West Plains Mo. Primary Registration District No. 4227
City West Plains Mo. File No. 49
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Inez Schultz
(a) Residence, No. _____ St., _____ Ward.
(Usual place of abode)

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 Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 14 - 1918

7. AGE YEARS MONTHS DAYS IF LESS than I day, _____ hrs. or _____ min.
26 8 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None 1923
(b) General nature of industry, business, or establishment in which employed (or employer) 1188
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Salem, Mo
(STATE OR COUNTRY) Deer Co

10. NAME OF FATHER Henry Schultz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Deer Co Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER M. J. Plank

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

14. INFORMANT Mrs. Denton
(Address) West Plains Mo.

15. FILED 9-20-28 1928 A. P. Kimmich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-17 1928
17.

I HEREBY CERTIFY, That I attended deceased from August 19, 1928, to Sept-17, 1928 that I last saw h. _____ alive on Sept 17, 1928, and that death occurred, on the date stated above, at about 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Gastritis
Chronic constipation
CONTRIBUTORY Insanition - Stomach
(SECONDARY) to death
(duration) yrs. mos. da. 2 mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH. No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Scapulous
(Signed) P. H. Spake, M. D.
9-20-28 (Address) West Plains 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 West Plains Mo DATE OF BURIAL Sept 17 1928

20. UNDERTAKER M. C. Farber's ADDRESS W. P. Mo

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.

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**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 Howell

Registration District No. 384

File No.

Township West Plains

Primary Registration District No. 4227

Registered No. 99

City West Plains

St. Ward

2. FULL NAME

(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 S
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 - 1903

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 (duration) yrs. mos. ds.
(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)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)....., M. D. , 19 (Address)

*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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30337