

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

Do not use this space.

32211

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City Schoues mo (No. City Dubuque)

File No. ....

Registered No. 3513

St. .... Ward)

**2. FULL NAME** Sophia North

(a) Residence. No. City Infirmary St. B Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 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)**

Widow

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** May 15 1850

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
78	4	10	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housework  
 (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)** Germany

**10. NAME OF FATHER** John Roessler

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

**12. MAIDEN NAME OF MOTHER** Elizabeth Walzmann

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

**14. INFORMANT** Mrs Effinger  
(Address) 1500 Central St

**15. FILED** 26 Wm C Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 9/25 1928

**17. I HEREBY CERTIFY**, That I attended deceased from 9/1, 1928, to 9/25, 1928, that I last saw him alive on 9/25, 1928, and that death occurred, on the date stated above, at 7:04 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of Cervix  
 (duration) 5 yrs. mos. ds.  
**CONTRIBUTORY (SECONDARY)** Chronic Myocarditis  
 (duration) 5 yrs. mos. ds.

**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?**

(Signed) Harold Moody, M. D.

(Address) Isolation Hospital  
 \*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** Holley Cross Cem. **DATE OF BURIAL** Sept. 28 1928

**20. UNDERTAKER** Burke Wood **ADDRESS** 3300 State St

E. H. Lewis

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.

