

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

Do not use this space.

5551

PLACE OF DEATH

County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph (No. Mo. Methodist Hospital)

File No. _____
 Registered No. 216
 St. _____ Ward _____

2. FULL NAME Sophia Elizabeth Schrier

(a) Residence. No. Savannah Mo. St. _____ Ward. Savannah Mo.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Louis Schrier</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 21, 1870</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hra. ormin.
	<u>58</u>	<u>6</u>	<u>28</u>	

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) Andrew Co.
 (STATE OR COUNTRY) Missouri

PARENTS	10. NAME OF FATHER <u>Nicholas Schneider</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Switzerland</u>
	12. MAIDEN NAME OF MOTHER <u>---Schlinder</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Ohio</u>

14. INFORMANT Louis Schrier
 Address Savannah Mo.

15. FILED 19 1929
John E. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 19 1929
 17. I HEREBY CERTIFY, That I attended deceased from 1/30/29 to 2/19/29 1929
 that I last saw h. OR... alive on 2/18/29, 1929, and that death occurred, on the date stated above, at 1:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of bladder
49 530
 (duration) yrs. mos. ds.
 CONTRIBUTORY Edema
 (SECONDARY) (duration) yrs. mos. ds.

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
 (Signed) Chas. Greenberg, M. D.
Feb. 19, 29 (Address) 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 <u>Savannah Mo</u>	DATE OF BURIAL <u>Feb. 21</u> 19 <u>29</u>
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20. UNDERTAKER <u>H. O. Sidenfaden</u>	ADDRESS <u>1802 Union St.</u>
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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.

WHITE FAINTLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

AR 21 1929
 23
 28
 2

