

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

Do not use this space.

5592

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. St. Joseph Hospital)

File No. _____
Registered No. 261
St. _____ Ward _____

2. FULL NAME Ella T. Schmitz

(a) Residence. No. 1118 Henry St St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 30 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 OF (OR) WIFE OF Joseph P Schmitz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 5, 1869

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	69	6	22	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

PARENTS	10. NAME OF FATHER <u>Thos. Powers</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Ireland</u>
	12. MAIDEN NAME OF MOTHER <u>Mary Ganbon</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Ireland</u>	

14. INFORMANT Joseph Schmitz
(Address) 1118 Henry St.

15. FILED 28 1929
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1929, to Feb. 27 1929 that I last saw h. OR alive on Feb. 26, 1929, and that death occurred, on the date stated above, at 7-30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis -
131 (Myocarditis)
92H
93C (duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) arterio sclerosis - Hydrothorax
chronic nephritis (duration) 5 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? Physical Exam - Lab tests
(Signed) J. S. Thompson M. D.

Feb. 27, 19 29 (Address) 825 Cherokee - 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>Kansas City Missouri</u>	DATE OF BURIAL <u>March 2 1929</u>
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20. UNDERTAKER <u>W. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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