

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

Do not use this space.

Der Ferreus
File No. **6119**
Registered No. **114**
St. _____ Ward _____

1. PLACE OF DEATH

County *Greene*
Township *Springfield*
City *Springfield* (No. *329*)

Registration District No. *318*
Primary Registration District No. *2001*

2. FULL NAME

(a) Residence, No. *529* *Marion* St., _____ Ward.
(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 *F* 4. COLOR OR RACE *A* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 2 1885*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u><i>73</i></u>	<u><i>10</i></u>	<u><i>10</i></u>	<u><i>5</i></u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Unknown*
(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) *Switzerland*

PARENTS

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *H. F. Lohmeyer*
(Address) *Springfield, Mo*

15. FILED *2/4* 19 *29* *W. Horst*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 3 - 1929*

17. I HEREBY CERTIFY That I attended deceased from _____
Jan 27 - 1929, to *Feb 3 - 1929*,
that I last saw him... alive on *Feb 3 - 1929*, and that death occurred, on the date stated above, at *6:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
931
29 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY *General arteriosclerosis*
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *411 B*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *W. Ferreus*

Feb 4, 1929 (Address) *Springfield, Mo*

*State the DISEASE CAUSING DEATH, or if death 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 *Presant Ave Mo* *2/4* 19 *29*

20. UNDERTAKER *W. Ferreus* ADDRESS *Springfield*

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.

MAR 22 1929

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