

24 1929

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

Do not use this space.

14344

1. PLACE OF DEATH

County..... Franklin Registration District No. #6 297
Township St Johns Primary Registration District No. 2974
City..... Krakow (No., St. Ward)

2. FULL NAME Anna Maria Schroeder--- Nee Ballmann

(a) Residence. No. Krakow Mo St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 18 da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Henry Frank Schroeder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 27th-1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 2 18

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) Krakow Mo
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Bernhard Ballmann

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

12. MAIDEN NAME OF MOTHER Angele Rolf

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Krakow
(STATE OR COUNTRY) Franklin County Mo

14. INFORMANT Henry Frank Schroeder
(Address) Krakow Mo

15. Apr. 17 1929 O. L. Yman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 15 1929

17. I HEREBY CERTIFY, That I attended deceased from April 10 1929, to April 15 1929, that I last saw her alive on April 15 1929, and that death occurred, on the date stated above, at 7:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pleurisy
1138 / 0215 (duration) yrs. - mos. 16 da.
CONTRIBUTORY (SECONDARY) 0215 (duration) yrs. 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? None
(Signed) Henry E. Dordick, M. D.
April 16 1929 (Address) Washington 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 Catholic Cemetery DATE OF BURIAL April 19th- 29 19
Krakow Mo

20. UNDERTAKER Otto & Co ADDRESS Washington Mo

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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 Franklin Registration District No. 297 File No. _____
 Township St. Johns Primary Registration District No. 0414 Registered No. 46
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Anna Maria Schroeder

(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 M
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 27 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 2 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

PARENTS
 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 April 17, 1929 O. L. Munch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/15 - 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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