

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

Do not use this space.

20671

PLACE OF DEATH

County Boone

Registration District No. 73

File No. 162

Township Columbia

Primary Registration District No. 3006

Registered No. _____

City _____ St. _____ Ward _____

2. FULL NAME

Jane Elizabeth Otto

(a) Residence. No. 509 Cherry St., _____ Ward. _____

(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

Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

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

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

June, 26-1890

7. AGE

| YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|-------|--------|------|--|
| 88 | 11 | 12 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home.

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Howard Co., Missouri

(STATE OR COUNTRY)

10. NAME OF FATHER

Henry C. Schwabe

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Mary Saudke

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Verdeer

14.

INFORMANT

(Address)

A. M. Schuber
Columbia, Mo.

15.

FILED 6-15-29

Beatrice Grubb
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June, 29, 1929.

17.

I HEREBY CERTIFY, That I attended deceased from _____
_____ 1929, to _____ 1929
that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ 5:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia. 2 side
7 yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

7 years duration (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. R. Sharp M. D.

6/10, 1929. (Address) Columbia, 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

DATE OF BURIAL

Dripping Spigi 6-9-1929.
20. UNDERTAKER W. H. Anderson Columbia, Mo.

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.

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