

APR 23 1930

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

Do not use this space.

7803

85

1. PLACE OF DEATH

County Buchanan

Registration District No. 1001

File No. 347

Township St Joseph

Primary Registration District No. Protes-Baptist Dist

Registered No. 347

City St Joseph

(No. Protes-Baptist Dist)

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Charles Schreiter

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
28 6 28

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Truck Driver  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer Newman Transfer Co Holt Co Mo

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

10. NAME OF FATHER Fred Schreiter

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

12. MAIDEN NAME OF MOTHER Rose Joslin

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

14. INFORMANT Allie Schreiter  
(Address) 516 E 10th St Joseph Mo

15. FILED 17 1930 REGISTRAR John L. M...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 16 1930

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, and that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ 5:40 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Fractured skull, result of Auto accident on Highway No 36 near Hamilton Mo.

210 M (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1880 (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? Xray  
(Signed) R. W. Jackson Coroner, M. D.

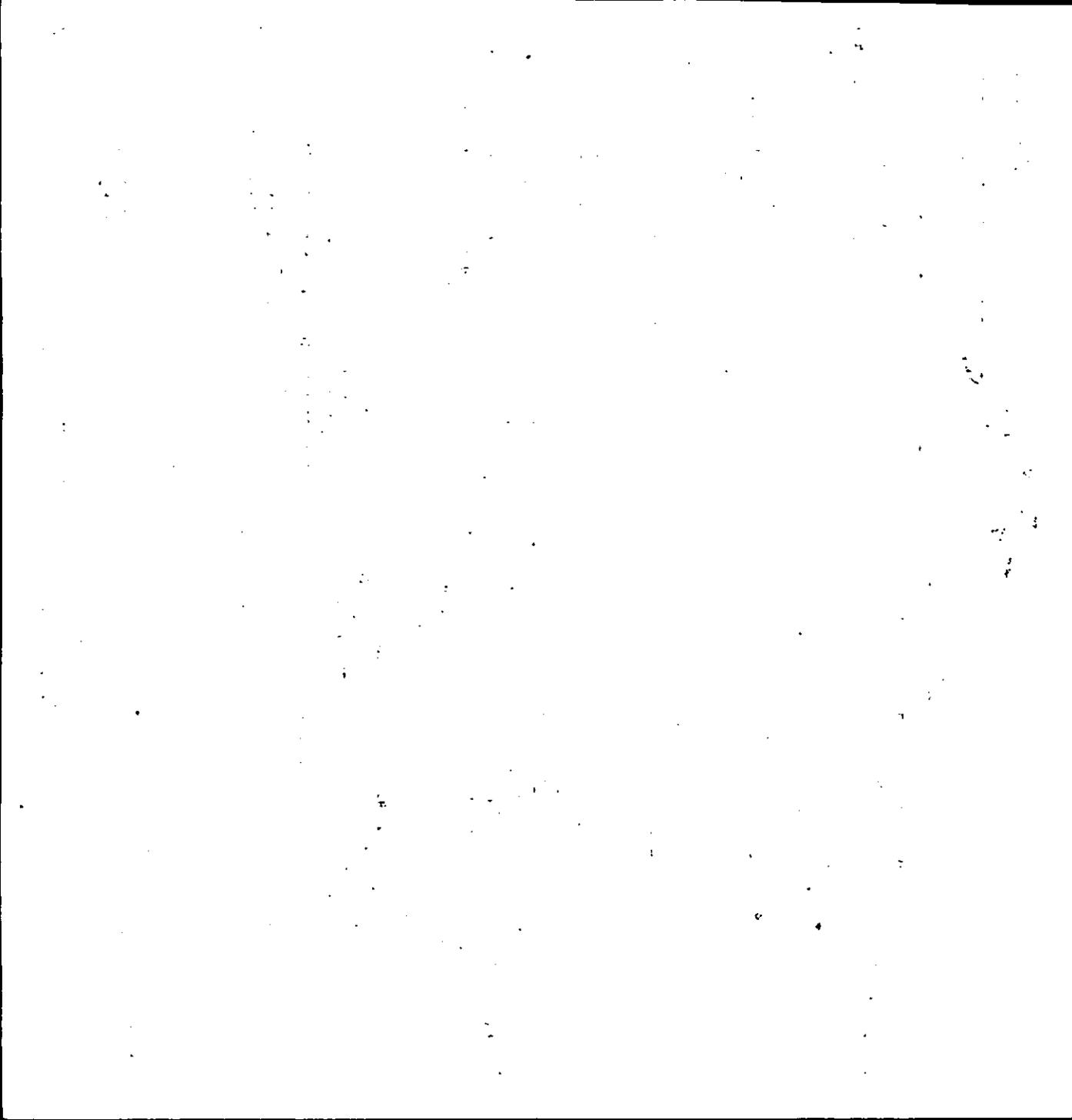
3/17-2330 (Address) St Joseph Mo.

\*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 Chillicothe Mo DATE OF BURIAL March 19 1930

20. UNDERTAKER Heeman Funeral Home ADDRESS 1946 Colburn

PARENTS



**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..... Registration District No. 85  
 Township..... Primary Registration District No. 1001  
 City St. Joseph (No. ....) St. .... Ward)

File No. 7803  
 Registered No. 347

**2. FULL NAME**

Charles Schreiter

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

m | w | m

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

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)

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 9-15-30 John H. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 6 1930

17. I HEREBY CERTIFY, That I attended deceased from .....

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:

Fractured skull result of auto accident on highway No 36 near Hamilton mo  
deceased's car collided with another car

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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? 1886

(Signed)....., M. D. 20/1  
 , 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

5-1803

CONTRACT NO. 603 60334003 AT&T SERVICES