

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

Do not use this space.

20205

JUL 23 1930

1. PLACE OF DEATH

County Osage
Township Jackson
City Meta (No., St. Ward)

Registration District No. 641
Primary Registration District No. 4385

File No. 7
Registered No.

2. FULL NAME

Herbert Henry Schriefer

(a) Residence, No. meta, 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 19 yrs. 9 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 2, 1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>19</u>	<u>9</u>	<u>0</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Engineer (3rd)
(b) General nature of industry, business, or establishment in which employed (or employer). Power Plant
(c) Name of employer

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

PARENTS	10. NAME OF FATHER <u>Henry J. Schriefer</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Babtown</u> (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>Gesina Mueller</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Babtown</u> (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT Alfred F. Schriefer
(Address) 13-E MILLER ST. JOFFREON, ILL. MO.

15. FILED 6-5, 1930 Robert Krater
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Electrocuted (Accidental)

193 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) + 1910 (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? no

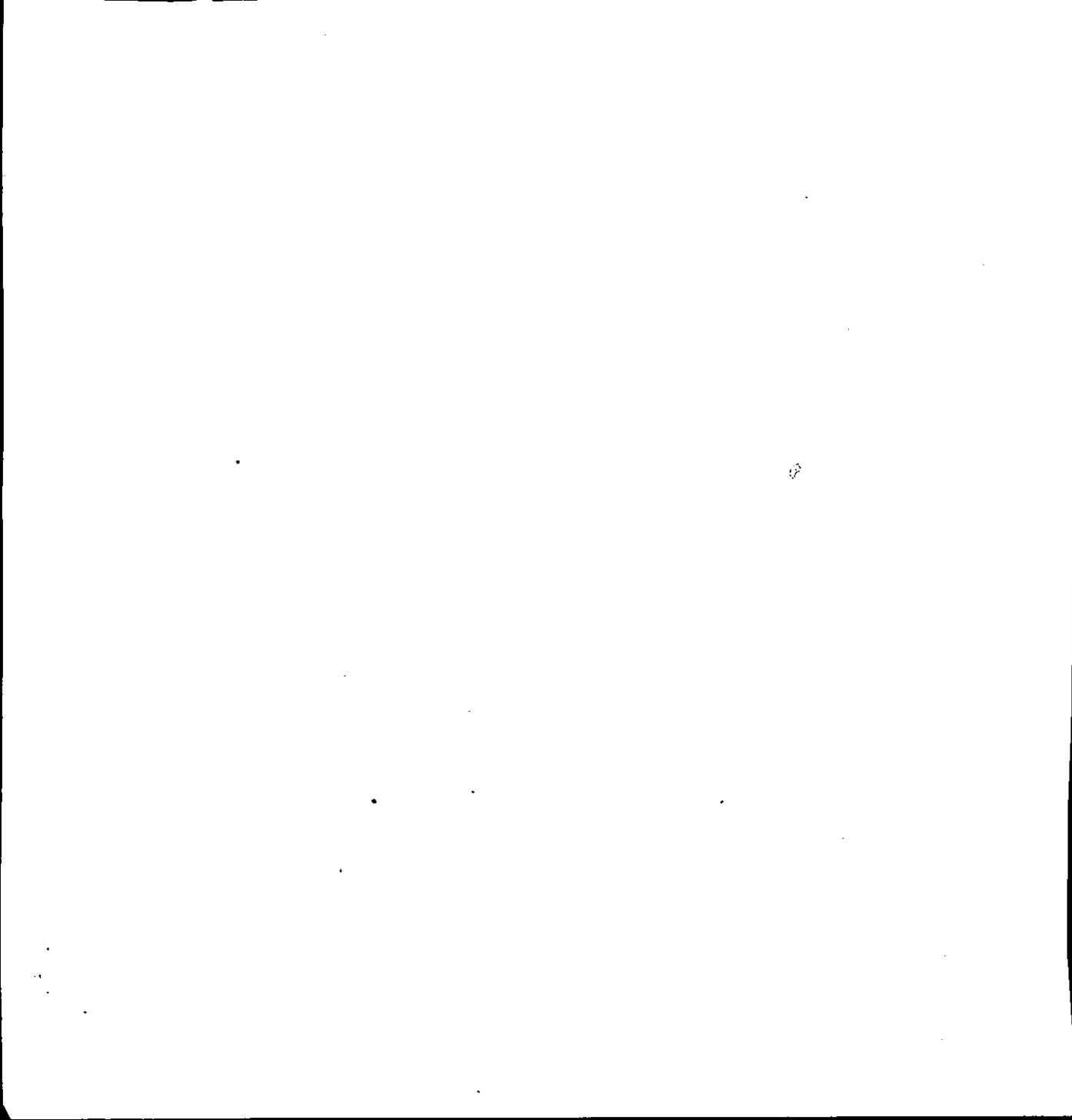
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) W. E. G. Meade, Coronar, Ochs
By Dr. S. H. Harrison, M. D.

6/2, 1930 (Address) Meta 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>Babtown Mo.</u>	DATE OF BURIAL <u>6/4</u> 19 <u>30</u>
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20. UNDERTAKER <u>Hawson & Lanner</u>	ADDRESS <u>Joffrean City Mo.</u>
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Did accident occur while
at work? yes.

6/2/30
S(2)-20205

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Ozage Registration District No. 641 File No. 20205
 Township Primary Registration District No. 4385 Registered No. 7
 City Meda (No., St. Ward)

2. FULL NAME

Herbert Henry Schiefer

(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 S
(write the word)

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 June 2, 1930 Robert Prater REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 - 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Electrocuted (accidental) while at work in sub station

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) g s, 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

19

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

SC-20205