

SEP 25 1930

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

Do not use this space.

1. PLACE OF DEATH

County Montgomery
Township Blue Creek
City (No. _____) _____

Registration District No. 596
Primary Registration District No. 5787B

27365
File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Joseph Francis Schwarzer
(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 37 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 11 1

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) Farmer
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Austria10. NAME OF FATHER Joseph Schwarzer11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Austria12. MAIDEN NAME OF MOTHER Unknown13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Austria14. INFORMANT Joe Schwarzer
(Address) New Stanton, Mo15. FILED 9.5 1930 W J Pover
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5th 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-3
1930, to 8-4 1930
that I last saw him alive on 8-3 1930, and that death occurred, on the date stated above, at 2:20 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Obstruction of intestine

129 (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? Yes DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS Clinical(Signed) H. R. Daxiniak, M. D.. 19 (Address) Bellflower Ind

*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

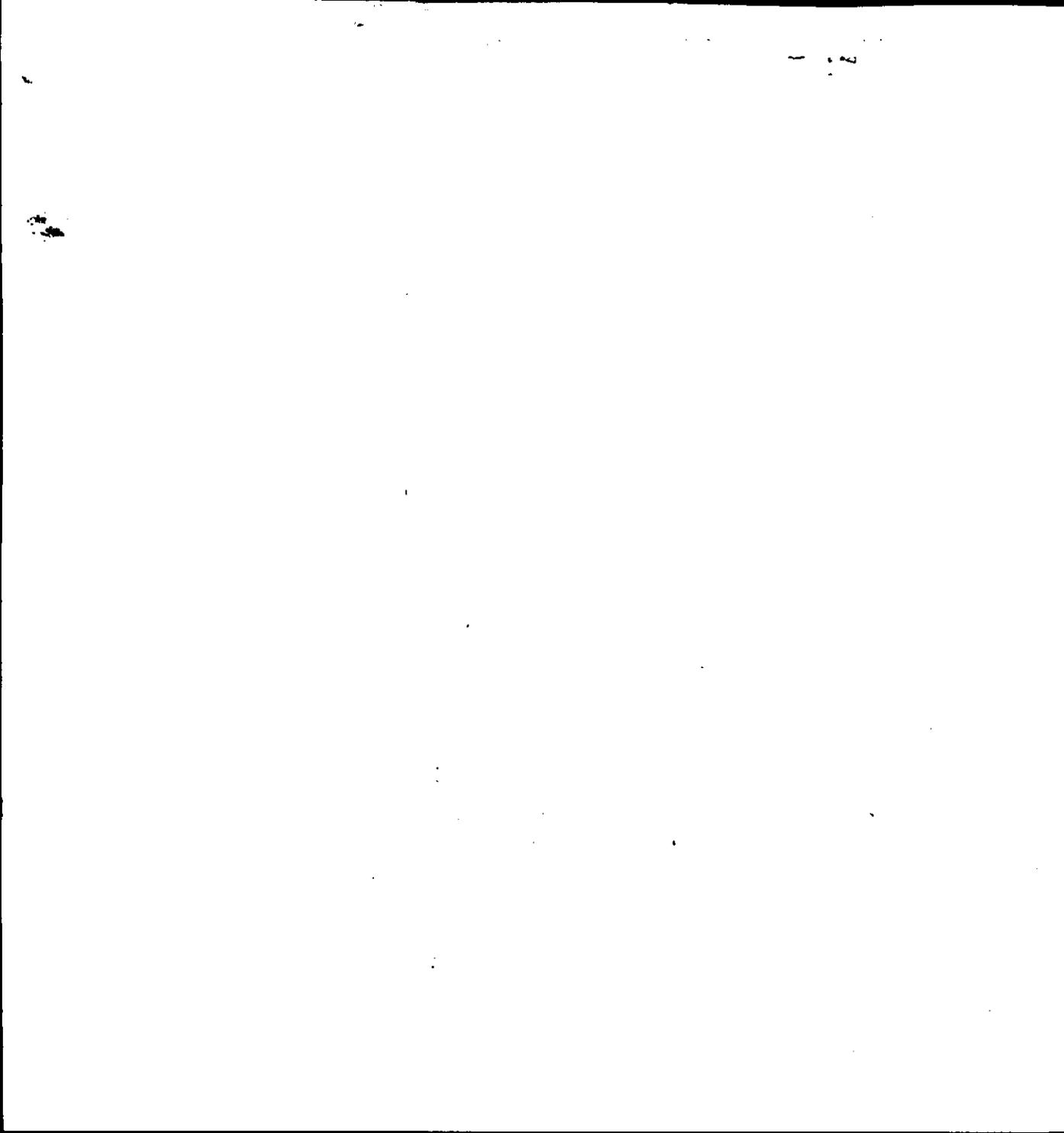
DATE OF BURIAL

Pin Oak Cemetery Aug 6th 1930

20. UNDERTAKER

ADDRESS

W J Pover Bellflower Ind



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Montgomery Registration District No. 596 File No.
 Township Washington Primary Registration District No. 5-787 B Registered No.
 City..... (No.....) St. Ward)

2. FULL NAME Joseph Frances Schwarzen
 (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 (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sept 5-1847

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 11 -- --

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 8/5-30 as above REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 1930

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:
Obstruction of intestines of
fair abnormal amount of fecal
matter collected causing a fecal plug.
 (duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 118 B 2
 (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRICTED 118 B 2
 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

D/BY LAW
PRI
CERTIFIC
REGISTRARS

SUPPLEMENT

S-27365