WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

JAN 19 1931

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

Do not use this space.

38974

1. PLACE OF DEATH
County Dent
Township Current
City ..... (No. ..... St. ..... Ward)

Registration District No. 1035
Primary Registration District No. 5371

File No. .....
Registered No. 12

2. FULL NAME Jacob Schaffer
(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 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
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: Francis R Schaffer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 4 - 1853

7. AGE: 77 YEARS, 8 MONTHS, 26 DAYS. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): Indiana

PARENTS
10. NAME OF FATHER: Christian Schaffer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: C W Schaffer
(Address) Montauk, Mo

15. FILED 1/2, 1931 J. A. Kissock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12 - 30 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Dec 29, 1930, that I last saw him alive on Dec 29, 1930, and that death occurred, on the date stated above, at 1:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic Interstitial Nephritis

131

(duration) 1 yrs. 2 mos. 15 ds.

CONTRIBUTORY (SECONDARY) 129a

(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) W. G. Dillon, M. D.
, 19 (Address) Salem 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: Green Forest Cem
DATE OF BURIAL: 12/31 1930

20. UNDERTAKER: B D Hobson
ADDRESS: Salem Mo