

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

Do not use this space.

1625

**1. PLACE OF DEATH**

County Johnson Registration District No. \_\_\_\_\_  
Township Kaw Primary Registration District No. \_\_\_\_\_  
City Kansas City (No. Westly) \_\_\_\_\_ St. \_\_\_\_\_ (Ward)

File No. \_\_\_\_\_  
Registered No. 458  
St. \_\_\_\_\_ (Ward)

**2. FULL NAME**

William J. Schroeder  
(a) Residence. No. Concordia 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 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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. W.J. Schroeder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 4, 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
33 2 1 26

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Trucking  
(b) General nature of industry, business, or establishment in which employed (or employer) Self. 104  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) 31

10. NAME OF FATHER Joel Schroeder

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

12. MAIDEN NAME OF MOTHER Beulah Busch

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

14. INFORMANT C.M. Reister (Address) Concordia Mo

15. Jan 30, 1931 M.M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 30, 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1931, to Jan. 30, 1931, that I last saw him alive on Jan. 30, 1931, and that death occurred, on the date stated above, at 9:20 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hypertension  
51A

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. G. Mackey M. D.

1-30, 1930 (Address) 3719 Forest Ave.

\*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

St. Mathew Lutheran Church Feb-1-1931

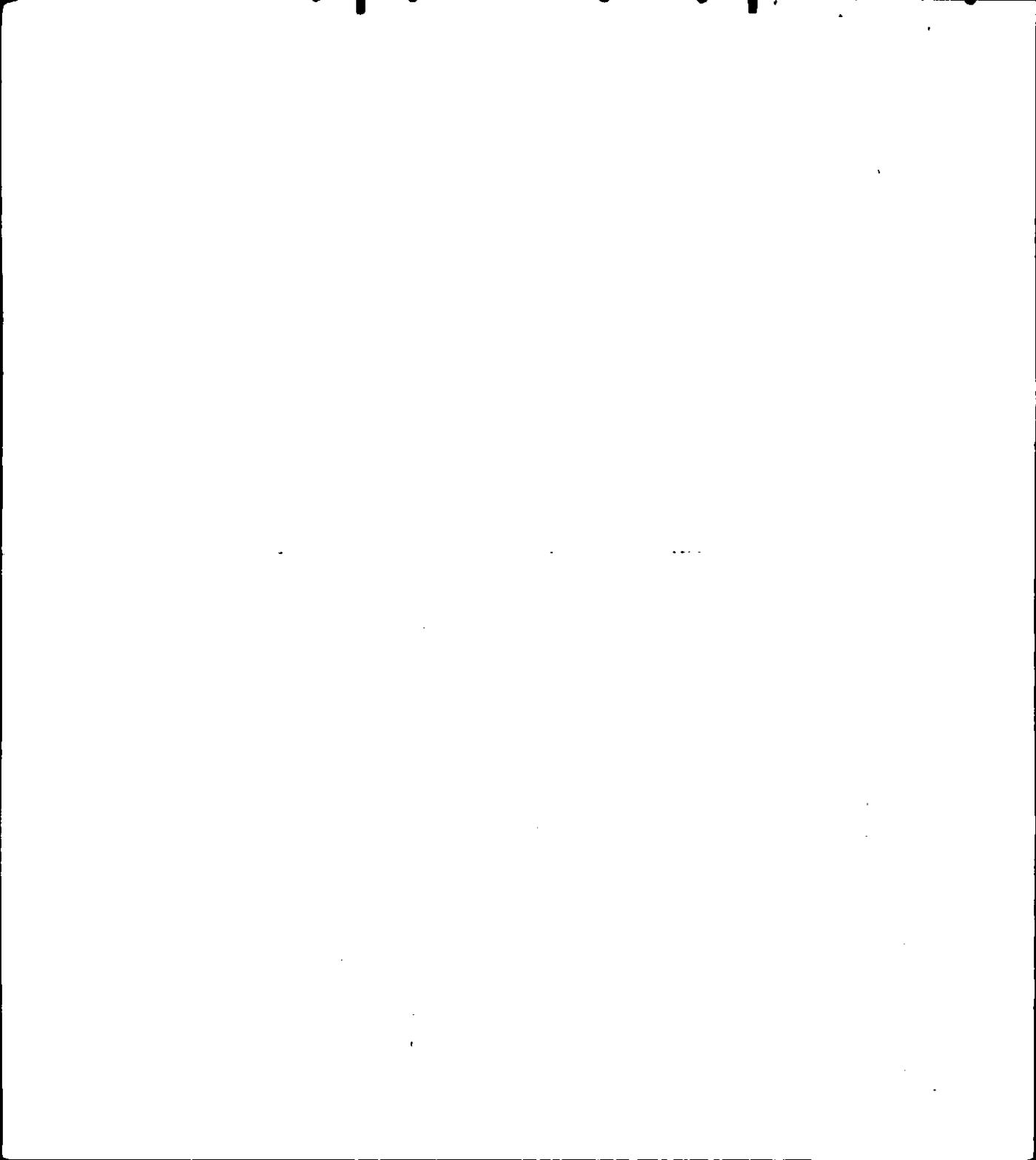
20. UNDERTAKER ADDRESS

H. S. Sweeney Concordia 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.

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

32



**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 .....  
Township X-Orty .....  
City X-Orty (No. ....)

Registration District No. 399  
Primary Registration District No. 1112

File No. ....  
Registered No. 458  
St. .... Ward)

**2. FULL NAME**

William J. Schroeder

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 4 - 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
33 X 2 26

**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

1/30 31 M. M. Crowe  
Ans REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 19 31

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

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Suppurative pneumonia  
of kidney  
(duration) ..... yrs. .... mos. .... da.

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? .....

(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**

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.

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

SUPPLEMENTARY

S-1625