

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

Do not use this space.

✓ 10608

1. PLACE OF DEATH

County Jackson Registration District No. 496
 Township Brookfield Primary Registration District No. 5660
 City Brookfield Mo (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence No. Brookfield Mo. St. R.F.D. West.

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-24 1931

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

22. I HEREBY CERTIFY, That I attended deceased from 3-18 1931 to 3-24 1931

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 20-1867

I last saw him alive on 3-21 1931. Death is said to have occurred on the date stated above, at 9:50 p. m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 64 yrs. 3 mos. 4 ds.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer 1

acute dilatation of heart. Date of onset 22A / 22B / 95B

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Mar 1, 1921 11. Total time (years) spent in this occupation 20

Other contributory causes of importance: Mitral Stenosis acute dilatation of ventricles

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brookfield Missouri

13. NAME Bernard Schaefer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Westphalia, Germany

15. MAIDEN NAME Margaret Baker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Polk Iowa

17. INFORMANT (ADDRESS) Mrs John Schreiner Brookfield Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St Michaels DATE 3/27/31

19. UNDERTAKER (ADDRESS) Huntz & Kellie Brookfield Mo

20. FILED 3-26 1931 Bessie M. Fore Registrar.

Name of operation none Date of 3-24
 What test confirmed diagnosis? ✓ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ✓ Date of injury _____, 19____

Where did injury occur? ✓ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ✓ Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) E. J. Jenkins M. D.
 (Address) Brookfield Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 24 1931

**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 Linn Registration District No. 296 File No.
 Township Brownfield Primary Registration District No. 5660 Registered No. 36
 City (No.) St. Ward)

2. FULL NAME

Joseph John Schaefer
 (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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/24 19 31

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

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., in 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:

Acute dilatation of heart

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

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

CONTRIBUTORY (SECONDARY) Mitral Stenosis
acute obstruction of intestine
Fecal matter

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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.

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

15. FILED 5-8 1931 Bessie M. Foret REGISTRAR

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

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