

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

Do not use this space.

7031

FEB 25 1932

1. PLACE OF DEATH
 County Scott Registration District No. 820
 Township Ylanca Primary Registration District No. 6069
 City Scott (No. _____) St. _____ Ward _____

2. FULL NAME Eddie Schramm
 (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.

File No. _____
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9/29/08
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
23 4 2
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farm
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/1 1932
 17. I HEREBY CERTIFY, That I attended deceased from May, 1932, to 2/1, 1932 that I last saw living alive on 2/1, 1932, and that death occurred, on the date stated above, at 3 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
2 3/4 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 2 3/4 (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) Mo (STATE OR COUNTRY)
 10. NAME OF FATHER Sam Schramm
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germe¹⁰ (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Francis Blatter
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No (1)
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) W. C. Clinch, M. D.
 , 19 (Address) Oran Mo

14. INFORMANT Sam Schramm
 (Address) Oran Mo
 15. FILED 2/9 1932 H. S. Slickman REGISTRAR

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Scott County DATE OF BURIAL 2/3 1932
 20. UNDERTAKER F. J. Haines & Co ADDRESS Oran

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

