

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.

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

Do not use this space.

5715

1. PLACE OF DEATH

County *Jackson* Registration District No. *009*  
Township *Rau* Primary Registration District No. *300*  
City *Kansas City, Mo* No. *Joseph Hospital*

File No. ....  
Registered No. *667* St. .... Ward)

2. FULL NAME

*Mrs Anna Schridx*  
(a) Residence, No. *Reserve Kansas* St. .... Ward.

(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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Harry W. Schmidt.</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>11-17-1869</i>				
7. AGE YEARS <i>63</i>	MONTHS <i>2</i>	DAYS <i>23</i>	If LESS than 1 day. .... hrs. or ..... min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>House wife</i>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>1700 10/24 B</i>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation.	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Nebraska</i>				
FATHER	13. NAME <i>Geo Kloepfel</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>			
MOTHER	15. MAIDEN NAME <i>Anna Buchman</i>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>			
17. INFORMANT <i>Harry Schmidt Jr</i> (ADDRESS) <i>2961 Charlotte</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Reserve Kansas</i> DATE <i>2/12</i> 19 <i>33</i>				
19. UNDERTAKER <i>O. V. MAST FUNERAL HOME, Inc.</i> (ADDRESS) <i>3146 Main St</i>				
20. FILED <i>1/9</i> 19 <i>33</i> <i>m. m. Brown</i> <i>Wm Registrar.</i>				

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-9-* 19*33*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 27* 19*33*, to *Feb 9* 19*33*  
I last saw *her* alive on *Feb 9* 19*33*. Death is said to have occurred on the date stated above, at ..... m.  
The principal cause of death and related causes of importance were as follows:  
*Pulmonary Embolus*  
Date of onset  
*11/24/32*

Other contributory causes of importance:  
*Thrombotic Phlebitis following appendectomy*

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....  
If so, specify *John O. Summer* M. D.  
(Address) *148 2nd Street 15th St*

15-296

235  
42  
10  
10

