

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

Do not use this space.

1. PLACE OF DEATH

County Barton
Township White
City Jonia (No. _____ St. _____ Ward _____)

Registration District No. 60
Primary Registration District No. 5095

File No. 3897
Registered No. 5

2. FULL NAME

Lorothy Angeline Schuberl
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) July 3 - 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
One 7 9 3

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
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) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jonia Mo R.F.D.

FATHER
13. NAME William F. Schuberl

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshall Mo

MOTHER
15. MAIDEN NAME Ellen R. Lutz

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo

17. INFORMANT (ADDRESS) M. F. Schuberl

18. BURIAL, CREMATION, OR REMOVAL
X PLACE Col. Camp DATE Feb 7, 1934

19. UNDERTAKER (ADDRESS) J. B. Callahan
Lincoln Mo

20. FILED Feb 8, 1934 Mr. Emory K. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb - 6 -, 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan - 24, 1934, to Feb - 6 -, 1934
I last saw her alive on Jan - 24, 1934. Death is said to have occurred on the date stated above, at 4:42 a.m.
The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia
Date of onset _____
Other contributory causes of importance: _____

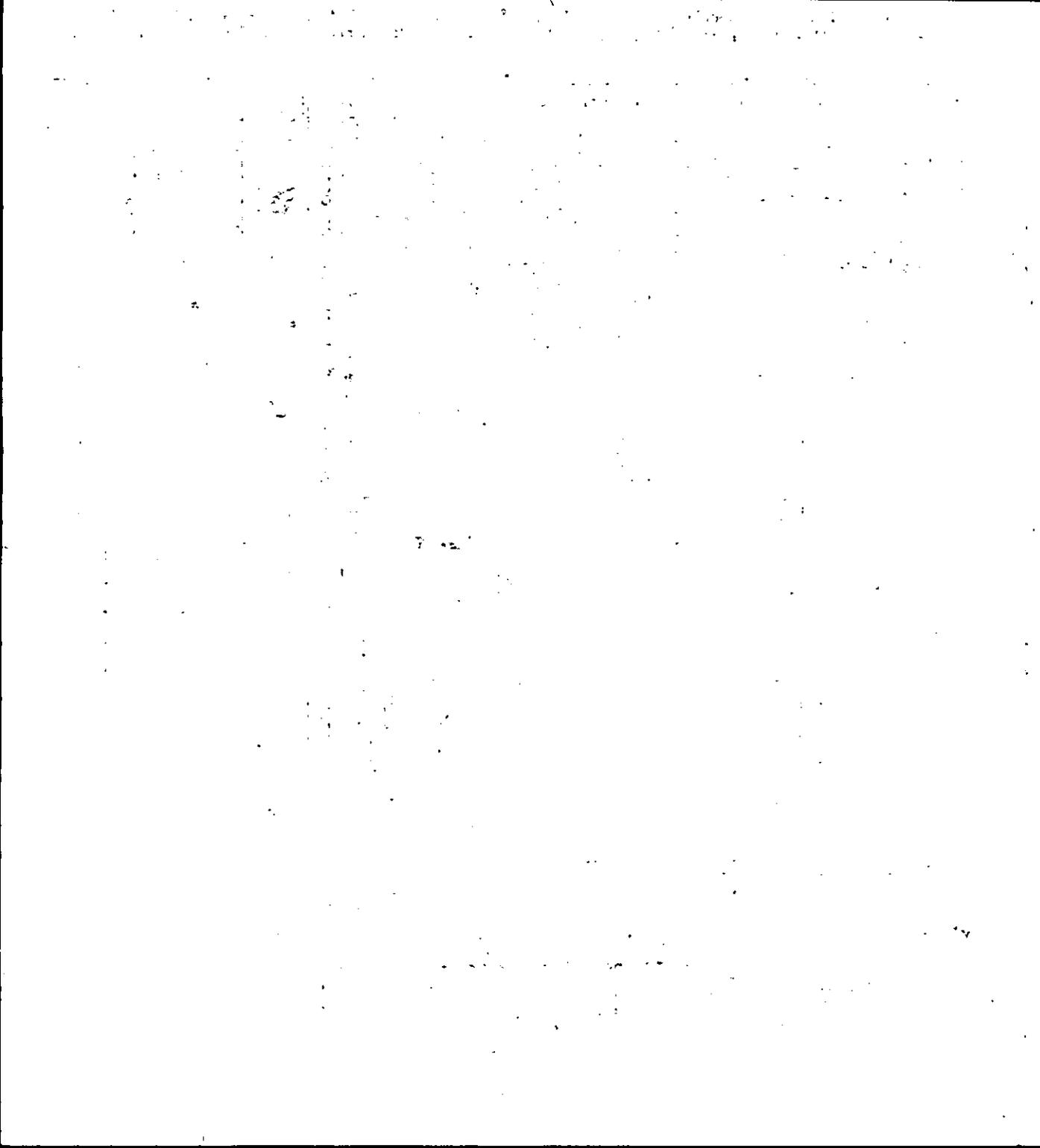
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____
(Signed) Orville R. Beedley, M. D.
(Address) Lincoln 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.



#2 *Benton*

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS 3897

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Dorothy Angelina Schubert*
Who died at _____ on *Feb-6-1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *1* Months *7* Days *3*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month *11* Year *1933*

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Brachio Neuronic*
Roentgen Infantile

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician *Dr. J. Cuddy, Lincoln Mo*

Address of physician *Mrs. Lily R. Roper* Date filed *Feb. 8-1934*

(Signature of Registrar) _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *60*

Very truly yours,

Primary Reg. Dist. No. *5095-*

E. T. Mc Gaugh M.D.
K.

Special Agent.

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