

MAR 2 1935

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

Do not use this space.

7183

1. PLACE OF DEATH

County..... Registration District No. 1000
Township..... Primary Registration District No.
City..... (No. 1000) St. Ward

File No.
Registered No. 1546

2. FULL NAME

(a) Residence, No. 3311 1/2 St., 18 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 13 - 1878

7. AGE YEARS 56 MONTHS 4 DAYS 2 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

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) Illinois

MOTHER 13. NAME John Ellis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

15. MAIDEN NAME Marta Waller

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Chas. J. Kelly (ADDRESS) City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE National Cemetery DATE Feb 18 1935

19. UNDERTAKER Feltz Bros (ADDRESS) 2029 Lafayette St

20. FILED 16 1935 19 J. T. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/15 1935

22. I HEREBY CERTIFY, That I attended deceased from 1/29 1935 to 2/15 1935

I last saw her alive on 2/15 1935 Death is said

to have occurred on the date stated above, at 3:28 m

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

arterio-sclerotic Heart Disease Date of onset

Other contributory causes of importance:

neuritis - rt. arm.

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) J. M. T. H., M. D.

(Address) City, 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.

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