

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan Registration District No. 100
Township _____ Primary Registration District No. _____
City St. Joseph (No. State Hosp #2) St. _____ Ward _____

85

4681

File No. _____
Registered No. 225 Ward _____

2. FULL NAME

William Schmidt
(a) Residence, No. Hugginsville 700 St. _____ Ward Hugginsville Mo
(Usual place of abode) _____
Length of residence in city or town where death occurred 36 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Abt 1858 ?
7. AGE YEARS 78 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Miller
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Flour Mill
10. Date deceased last worked at this occupation (month and year) First 1900 11. Total time (years) spent in this occupation? _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

13. NAME William

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

15. MAIDEN NAME Buchanan

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

17. INFORMANT (ADDRESS) Records State Hosp #2, St. Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Crescent Cem DATE Feb 25 1936

19. UNDERTAKER (ADDRESS) Stamley & Son Home

20. FILED 2-25 1936 John R. Boudin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 18 1936
22. I HEREBY CERTIFY, That I attended deceased from Nov 19 1935 to 2-18 1936
I last saw h. l. m. alive on 2-18 1936 Death is said to have occurred on the date stated above, at 11:55 pm.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Senility
Other contributory causes of importance: _____
Date of onset 11-19-35

Name of operation None Date of _____
What test confirmed diagnosis Clinical Lab Was there an autopsy? Yes

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) D. C. Dr. Long, M. D.
(Address) State Hosp #2

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.

