

DEC 28 1937

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

Do not use this space.

1. PLACE OF DEATH

County *St. Genevieve*Registration District No. *781*Township *Beaumont*Primary Registration District No. *6027*

City (No.)

St. Ward)

File No. *42348*

Registered No.

2. FULL NAME *Magdalena Schmeigert*

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *unmarried*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Andrew Schmeigert*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 11 1862*7. AGE YEARS *75* MONTHS *5* DAYS *9* If LESS than 1 day, hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *at home*

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) *Germany*13. NAME *Roman Roth*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*15. MAIDEN NAME *Magdalena Deitmyer*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*17. INFORMANT (ADDRESS) *John Schmeigert*18. BURIAL, CREMATION, OR REMOVAL PLACE *Ozark Mo* DATE *Jan 23 37*19. UNDERTAKER (ADDRESS) *W. C. Basha*20. FILED *11/22- 1937* *Goldthorn* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 20, 1937*22. I HEREBY CERTIFY, That I attended deceased from *Oct 25 1937* to *Nov 20 1937*I last saw her alive on *Nov 20 1937* Death is said to have occurred on the date stated above, at *12:30 p.m.*

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

Hypostatic pneumonia Date of onset *11/5/37*Other contributory causes of importance: *Hepatitis* *Unknown*Name of operation *None* 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 *no*(Signed) *J. A. Wilkens* M. D.(Address) *St. Genevieve, Mo.*

132a

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

4-2348
Do not use this space.

1. PLACE OF DEATH

(a) County St. Genevieve Registration District No. 981
(b) Township Seawards Primary Registration District No. 60-27 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Madgalena Schureigant

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) and

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75- 5 9

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 22, 1938

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 20, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h..... alive on _____, 19____. 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:

Hepatic Pneumonia

Date of onset

Other contributory causes of importance

Nephritic (Chronic)

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. A. Wilkins, M. D.

(Address) St. Marys mo

