

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

Do not use this space.

37

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791

1003

File No.

Registered No. W 93

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City..... (No.....)

St. Ward)

2. FULL NAME

William Schaefer

(a) Residence. No. 1915 John Ave. St. 9 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Christine Schaefer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 3, 1855*

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>71</i>	<i>2</i>	<i>28</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Cabinet maker.*

(b) General nature of industry, business, or establishment in which employed (or employer) *Planing mill*

(c) Name of employer *Central Mill Co.*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *William Schaefer*

(STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *unknown*

(STATE OR COUNTRY) *Germany*

14.

INFORMANT *Mrs. Wm. Schaefer*
(Address) *1915 John Ave.*

15.

FILED *111 -4 1027*
19 *1927* *Max C. Starkeoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 31 1926*

17. I HEREBY CERTIFY, That I attended deceased from *Nov. 17*, 19 *26*, to *Dec 31*, 19 *26* that I last saw him alive on *Nov 3*, 19 *26*, and that death occurred, on the date stated above, at *10:25 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Woman's Myocarditis

(duration) yrs. *2* mos. *16* ds.

CONTRIBUTORY (SECONDARY)

90 B

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Ernest R. ...* M. D.
Jan 2, 1927 (Address) *1918 9. ...*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Bethlehem Cem.

Jan 4. 1927

20. UNDERTAKER

ADDRESS

Theo. W. Beiderwieden

37. Louis ave.

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.

