

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

Do not use this space. **1452**

FILED 21 1928

1. PLACE OF DEATH

County Jackson
Township Franklin
City Jackson (No. _____)

Registration District No. 400
Primary Registration District No. 2553 B

File No. _____
Registered No. 13
St. _____ Ward _____

2. FULL NAME

Anna Schaub
(a) Residence. No. Jackson Co. Home Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 da. How long in U.S., if of foreign birth? yrs. mos. da.

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) about 1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>About</u>	<u>70</u>	<u>5</u>	<u>10</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Herman Missouri

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY) Unknown

14. INFORMANT J. M. Hostetter
(Address) Supt. Jackson Co. Home

15. FILED 1-26-28 J. M. Schick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-26-1928

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16th, 1928, to Jan. 26, 1928 that I last saw h. or alive on Jan. 21, 1928, and that death occurred, on the date stated above, at 8:45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Burned on left shoulder and hip
180 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. M. Greene M. D.
, 19 (Address) Independence Mo

*State the DISEASE CAUSING DEATH, 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 Washington DATE OF BURIAL 1/28 1928

20. UNDERTAKER A. J. DEHNER MORTUARY ADDRESS City

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.

Almond SWAIC
Y is AWA

State of Illinois
County of Cook

Witness my hand
this 1st day of

IN WITNESS WHEREOF
I have hereunto set my hand
and the seal of said Court
this 1st day of

1911

Handwritten signature or mark

Small handwritten mark

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson

Registration District No. 400

File No.

Township Prairie

Primary Registration District No. 555 2 B.

Registered No.

City (No.) St. Ward)

2. FULL NAME Anna Schubert

(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 P 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILE B-13-28 F.M. Schick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1928

17. I HEREBY CERTIFY, That I attended deceased from 1-21, 1928, to Jan 26, 1928 that I last saw h. alive on, Jan 26, 1928, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Burnt on left shoulder and hip by accidentally falling in stove

CONTRIBUTORY (SECONDARY) 179 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J.M. Schick M.D.
, 19 Independence Mo

*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

19

20. UNDERTAKER ADDRESS

N. B. CAUSE of death should be carefully supplied. AGES should be carefully supplied. PHYSICAL condition of OCCUPATION very important. REGISTRATION DISTRICTS ARE COMPLETE AS PRESCRIBED BY LAW. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THE INFORMATION IS IN PLAIN TYPE.

SUPPLEMENTARY

5-1452