

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

Do not use this space.

5745

**1. PLACE OF DEATH**

County Montgomery Registration District No. 875-  
 Township Millonfork Primary Registration District No. 4339  
 City Tipton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Anthony W. Schwanz  
 (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 49 yrs. 16 mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-11-1930

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

17. I HEREBY CERTIFY, That I attended deceased from 2-11-1930 to 2-11-1930, that I last saw him alive on 2-10-1930, and that death occurred, on the date stated above, at 1:00 a.m.

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>49</u>	<u>0</u>	<u>16</u>	

Endo-Carditis

**8. OCCUPATION OF DECEASED**

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

9233  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) 90%  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER Wendel Schwanz

O DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) J. B. Norman, M. D.  
 , 19 (Address) Tipton Mo

12. MAIDEN NAME OF MOTHER Anna Brach  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Angola New York  
 (STATE OR COUNTRY)

\*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.

14. INFORMANT George Schwartz  
 (Address) Tipton Mo

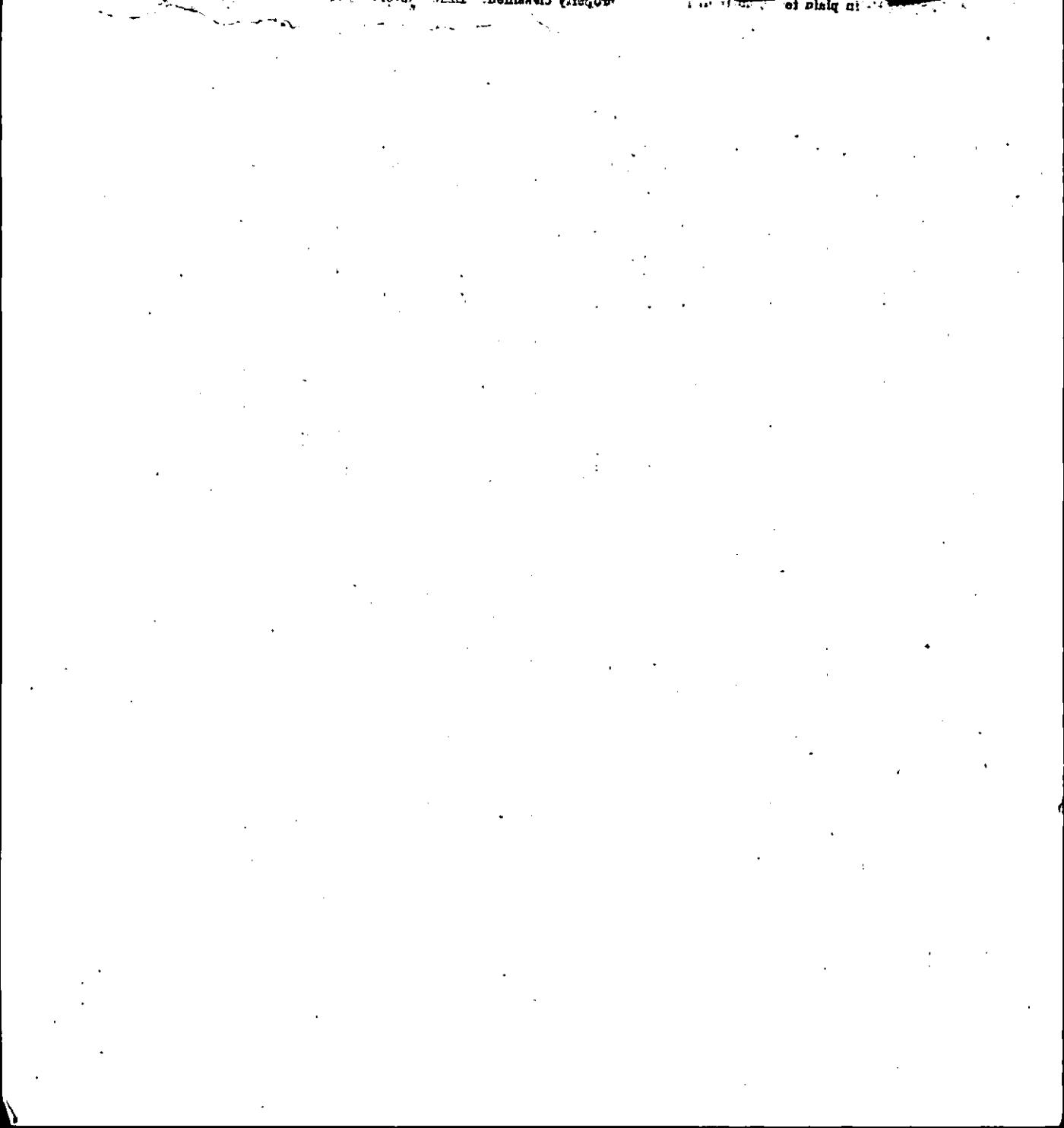
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Catholic Cemetery DATE OF BURIAL 2/13 1930

15. FILED 2-12-30 Mrs Sarah Frye REGISTRAR

20. UNDERTAKER L. G. Schreff ADDRESS Tipton Mo

CAUSE \_\_\_\_\_ H in plain terms, that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 28 1930



**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 Moniteau Registration District No. 575- File No. ....  
 Township ..... Primary Registration District No. 4339 Registered No. ....  
 City Tipton (No. ....) St. .... Ward .....

2. FULL NAME

(a) Residence. No. .... St. .... Ward Resident  
 (Usual place of abode) (If non-resident 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/11 19 30

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

I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date same above, at ..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-16-1881

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
49 | - | 16

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

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
 (c) Name of employer .....

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) ..... M. D.  
 , 19 (Address) .....

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. FILED 2-12-30 W. C. E. Frye REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
 ADDRESS 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

CAUSE OF DEATH IN plain terms, that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-5748