

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

Do not use this space.

8717

**1. PLACE OF DEATH**

County Jackson  
Township St. Joseph  
City St. Joseph (No. St. Joseph North)

Registration District No. 350  
Primary Registration District No. 1034

File No. \_\_\_\_\_  
Registered No. 1034  
St. \_\_\_\_\_ Ward

**2. FULL NAME**

Mrs Anne E Schofield  
(a) Residence. No. 4208 Belkourtain St. Ward. 16  
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

F

**4. COLOR OR RACE**

wh

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

married

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

Jos S. Schofield

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

Nov 12 1892

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>37</u>	<u>3</u>	<u>28</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at home  
(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) La

**10. NAME OF FATHER**

Jos P Schuck

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) no data

**12. MAIDEN NAME OF MOTHER**

no data

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) no data

**14. INFORMANT**

Jos S Schofield  
(Address) 4208 Belkourtain

**15. FILED**

3/11 19 30 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 3-11 1930

**17. I HEREBY CERTIFY** That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

General Peritonitis

12.14

12.9 (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)** ruptured appendix (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

**20. WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?**

3/10 (Signed) Henry M. Hall M. D.

3/10 1930 (Address) St. Joseph

\*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**

Catholic La

**DATE OF BURIAL**

3/11/30 19

**20. UNDERTAKER**

W. F. Mayberry La City, Mo

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.

235  
2  
31

