

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

Do not use this space.

10148

1. PLACE OF DEATH

Country Jackson
Township Flaco
City New (No. General Hospital)

Registration District No. 388
Primary Registration District No. 1925

File No. _____
Registered No. 17522
St. _____ Ward _____

2. FULL NAME

Mrs Irene Schmidt

(a) Residence. No. 1803 Charlotte St. 3 Ward.

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Joseph F. Schmidt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
68 5 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nursewife 23
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer _____

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

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not known

14. INFORMANT (Address) Joe F. Schmidt
1803 Charlotte

15. FILED 3/24 1931 M. M. Kerowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 22 1931

17. I HEREBY CERTIFY That I attended deceased from _____
Deputy Coroner, 19____, to _____, 19____,
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:

Accidental Automobile
Fracture of Skull
Pedestrian
210M (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 210 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF _____
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Henry M. Hale, M. D.
3/22, 1931 (Address) Deputy Coroner

*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 Cemetery DATE OF BURIAL March 26 31

20. UNDERTAKER R. L. Lindsey & Son 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.

