

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

Do not use this space.

32561

1. PLACE OF DEATH

County Cole
Township Centertown
City (Near) Centertown

Registration District No. 211
Primary Registration District No. 5291

File No. _____
Registered No. 11
St. _____ Ward _____

2. FULL NAME Albert Herman Schroer.

(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 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 Mrs. Schroer.

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 (Do not know)

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(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) Germany

10. NAME OF FATHER Albert Schroer.

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

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY), Do not know

14. INFORMANT Ben Schroer (Son)
(Address) Centertown, Mo

15. FILED Oct 13 19 33 H. T. Leach, M. D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 22, 19 33

17. I HEREBY CERTIFY, That I attended deceased from December 25, 19 32 to October 22, 19 33.
that I last saw him alive on October 21, 19 33 and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Heart Disease

Do not know (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Arterio-Sclerosis.
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Probably at place of
Death

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS none
(Signed) Frank S. Nichols, M. D.

, 19 (Address) Centertown, 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 St. Martin's Parish Cem- gtery, Centertown, Mo. DATE OF BURIAL Oct. 24 19 33

20. UNDERTAKER Dawson - Tanner Jeff City, Mo
ADDRESS

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.

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