WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

15475

**PLACE OF DEATH**

County Cape Girardeau

Township ____ or Village ____ or City Cape Girardeau (No 531 S Ellis St. 3 Ward)

Registration District No. 195 Primary Registration District No. 3009

File No. ____ Registered No. 1167

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** Johanna Schimme

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
|---|---|---|
| Female | White | Widow |

DATE OF BIRTH: Feb 16 (Month) (Day), 1851 (Year)

AGE: 64 yrs. 2 mos. 13 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): "

BIRTHPLACE (City or town, State or foreign country): Cape Co

PARENTS

NAME OF FATHER: Henry Sander

BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

MAIDEN NAME OF MOTHER: Louise Muckey

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Isenhoffe

(ADDRESS) Cape Girardeau Mo

Filed May 1, 1915 Geo. E. Chappell REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: April 29 (Month) Thursday (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 28, 1915, to April 29, 1915, that I last saw her alive on April 27, 1915, and that death occurred, on the date stated above, at 10 38 m.

The CAUSE OF DEATH* was as follows:

Chronic Paralysis Agitans

Nephritis

about 1 20

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. A. Schoen M. D.

Apr 30, 1915 (Address) Cape Girardeau Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| Fairmont | May 2, 1915 |
| UNDERTAKER | ADDRESS |
| M. J. Lorberg | Cape Gir |

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....
*or*
Village..... Primary Registration District No..... Registered No.....
*or*
City ..... (NO. ....., ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME**.....

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL<br>....., 191..... |
|---|---|
| UNDERTAKER | ADDRESS |

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 import

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