

APR 12 1939

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

8382
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No. Registered No. **2147**
(c) City (d) Street No. **BARNES HOSPITAL** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **5 1/2 AMELIA RUTH SCHOONOVER**

(a) Residence, No. St. **N.R.** **Salem, Ills.**
(Usual place of abode, if no street address, write county or city) (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 **Herbert Schoonover**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 21, 1910**

7. AGE. YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28 8 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kentucky.**

FATHER 13. NAME **Frank Walker**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kentucky**

MOTHER 15. MAIDEN NAME **Dorna Seople**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kentucky**

17. INFORMANT **Herbert Schoonover**
(ADDRESS) **Salem, Ills.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Salem, Ills.** DATE **3/8/39.**

19. FUNERAL DIRECTOR **Albert H. Hoppe, Inc.**
(ADDRESS) **4700 Washington Blvd.**

20. FILED **Mar. 6, 1939**
J. P. Bradshaw Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mar 4 1939**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at **1:45 P.M.**
The principal cause of death and related causes of importance were as follows:

Legal Poisoning of Self Administered at her home at 213 S Broadway, Salem Ill, on February 24th 1939 about 3:00 pm while suffering from a mental aberration

Name of operation Date of operation
What best confirmed diagnosis? Was there an autopsy? **no.**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **suicide** Date of injury **2/24**, 19**39**
Where did injury occur? **Salem Ill** (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. **Home**

Manner of injury **as above**
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) **Alfred J. Perry** M. D.
(Address) **deputy coroner**

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.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....
L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS 791
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... **1003**
 (b) Township..... Primary Registration District No..... **BARNES HOSPITAL** Registered No..... **2147**
 (c) City **St. Louis, Mo** (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Amelia Ruth Schoonover**

(a) Residence, No. St. **NR** **Salem Ill**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **JUNE 21, 1910**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28 8 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ken.**

FATHER 13. NAME **Frank Walker**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ken.**

MOTHER 15. MAIDEN NAME **Berna Sepple**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ken.**

17. INFORMANT (ADDRESS) **HUB AND Herbert Schoonover Salem Ill.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Salem Ill** DATE **March 8, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Alfred H. Hoyle 4700 Washington St.**

20. FILED **MAR 6 1939** **J. D. Redick** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 4, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **2-26**, 1939, to **3-4**, 1939

I last saw her alive on **3-1**, 1939 Death is said to have occurred on the date stated above, at **1:45 p.m.**

The principal cause of death and related causes of importance were as follows:

Lysol poisoning
 ① **Uremia**
 ② **Acute nephritis**
 ③ **Acute pericarditis (uremic)**

Date of onset

Other contributory causes of importance
U

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **suicide** Date of injury **2-20, 1939**
 Where did injury occur? **Salem Ill.**
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. **Home**

Manner of injury **Disallowed Lysol**
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) **Harry Wiese**, M. D.
 (Address) **BARNES HOSPITAL**

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.

5-8372

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed *J. G. Sullivan*

Licensed Embalmer No. *1122*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.