

JUN 15 1939

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

19210
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 548.
(b) Township Liberty Primary Registration District No. 5740. Registered No. 28.
(c) City Pattonville (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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

Anthony J. Schaaf
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 7, 1866
7. AGE YEARS 73 MONTHS 2 DAYS 14 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired R.R.
9. Industry or business in which work was done, as saw mill, bank, etc. Employe
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 21, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 1-4, 1938 to April 21, 1939
I last saw him alive on April 21, 1939 Death is said to have occurred on the date stated above, at 7:45 a.m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of basal & rings

Date of onset

Other contributory causes of importance: no

Name of operation none Date of _____
What test confirmed diagnosis Physician Was there an autopsy? no

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

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signature) W. T. G. Reller M. D.
(Address) Rollingwood

12. BIRTHPLACE (CITY OR TOWN) Peru (STATE OR COUNTRY) Indiana
13. NAME Anthony Schaaf
14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
15. MAIDEN NAME Anna Peters
16. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
17. INFORMANT Mrs. August Pohlman (ADDRESS) Pattonville MO
18. BURIAL, CREMATION, OR REMOVAL PLACE Kirkwood DATE April 23, 1939
19. FUNERAL DIRECTOR (NAME) Fred Karle (ADDRESS) Kirkwood Mo
20. FILED April 29, 1939 Gertrude Zell Local Registrar.

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.

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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 Fred J Kasse

Licensed Embalmer No. 1023

P. O. Address Kahoka Mo

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.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County Marion Registration District No. 348
 (b) Township Liberty Primary Registration District No. 3740
 (c) City..... (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

(a) Residence, No. Anthony J. Schaaf St. 6
 (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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (<u>8</u> the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>73</u>	MONTHS <u>2</u>	DAYS <u>14</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	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		
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
	13. NAME			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
	15. MAIDEN NAME			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED 19..... Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 21 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..... m.

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

Cardiomyopathy Bowel
and liver
not definite. No
exploration permitted
n. m. l.

Date of onset

Other contributory causes of importance:
Hb

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify
 (Signed) T. G. Roselle M. D.
 (Address) Palmyra Mo

SUPPLEMENTARY

