

DEC'D JUN 19 1939

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

19623

Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 756
 (b) Township Postage Box 210 Primary Registration District No. 5997
 (c) City or Black Walnut (d) Street No. Black Walnut 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

William Schroeder
 (a) Residence, No. Black Walnut 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>—</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct. 7, 1866</u>		
7. AGE	YEARS <u>72</u>	MONTHS <u>7</u>
	DAYS <u>4</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farming</u>	11. Total time (years) spent in this occupation
	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)	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Black Walnut Mo.</u>		
FATHER	13. NAME <u>Joseph Schroeder</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
MOTHER	15. MAIDEN NAME <u>Mary Kaufmann</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>	
17. INFORMANT (ADDRESS) <u>Frank Knochle</u> <u>Black Walnut Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Postage Box 210</u> PLACE <u>St. Charles, Mo.</u> DATE <u>May 15, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>H. C. Walling's Sons Co.</u> <u>St. Charles, Mo.</u>		
20. FILED <u>May 15, 1939</u> <u>Rose Barnard</u> <u>Sub. Local Registrar.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from Medical Reasons on May 12, 1939, to —, 19.....
 I last saw h. — alive on —, 19..... Death is said to have occurred on the date stated above, at 7:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
apoplexy
 Other contributory causes of importance: St. Ch.
 Date of onset

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
 If so, specify —
 (Signed) Joseph F. Mahony M.D.
677 (Address) St. Charles, Mo.

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.....

Licensed Embalmer No.....

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.