

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

21386
 Do not use this space.

JUL 18 1939

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
 (b) Township Beattie Primary Registration District No. 3001
 (c) City Hicksville (d) Street No. St. James Smith Hosp & Clinic 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. Green City, Missouri 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 Female 4. COLOR OR RACE White 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) Aug 8, 1928
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
10 10 9
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-17 1939
 22. I HEREBY CERTIFY, That I attended deceased from June 17, 1939 to June 17, 1939.
 I last saw her alive on June 17, 1939. Death is said to have occurred on the date stated above, at 11:30 pm.
 The principal cause of death and related causes of importance were as follows:

Pneumonia (broncho)
Lung abscess
107 W
 Other contributory causes of importance:
Rupture of abscess into pleura
 Date of onset 5-15-39
5-29-39
6-16-39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nowinger Mo

FATHER 13. NAME Charles Schooker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unionville Mo

MOTHER 15. MAIDEN NAME Agnus Cashill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mendota Iowa

17. INFORMANT (ADDRESS) Charles Schooker Green City, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Green City Cem. DATE June 19, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Glenn E. Kent & Son Green City, Mo

20. FILED June 24, 1939 Spencer H. Treeman Local Registrar

Name of operation Thrombosis Date of 6-17-39

What test confirmed diagnosis? Wray & fluid 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? No

If so, specify _____ (Signed) George E. Grinn, M. D.

(Address) Hicksville, Missouri

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.

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2
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RECEIVED
District Health Officer No. 10
District File Number 7-37-1289
Date Filed JUL 13 1939

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.