

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

39577
Do not use this space.

1. PLACE OF DEATH *REC'D DEC 15 1939*

(a) County *Stearns* Registration District No. *314*
 (b) Township *Stearns* Primary Registration District No. *4190*
 (c) City *Stearns* (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 *Miss Helen Agnes Schiefelbusch*

(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 *Single*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 19 - 1898*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
40 10 29

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Emp Tel Co*
 9. Industry or business in which work was done, as saw mill, bank, etc. *office*
 10. Date deceased last worked at this occupation (month and year) *Nov 18 - 1939* 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Harrison Co, Md*

13. NAME *Henry M. Schiefelbusch*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dunnington Iowa*

15. MAIDEN NAME *Anne E. Hagart*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alcona Iowa*

17. INFORMANT (ADDRESS) *Mrs Will Merning Stearns Mo*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *St. Mary's Cemetery* DATE *11/21/39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Wm J. Kelly & Co, 210 Stearns, Mo*

20. FILED *11/20/39* *W. S. Zeman* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 18 1939*

22. I HEREBY CERTIFY That I attended deceased from *5:30 PM Nov 18, 1939, to 9:30 PM Nov 18, 1939*

I last saw her alive on *Nov 18, 1939* Death is said to have occurred on the date stated above, at *9:30 P* m.
 The principal cause of death and related causes of importance were as follows:
*Cerebral thrombosis
apoplexy*

Date of onset *11-18-39*

Other contributory causes of importance:
*Hypertension
colitis*

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? *No*
 If so, specify _____

(Signed) *R. J. Sullivan*
 (Address) *Stearns, Mo*

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.

RECEIVED

District Health Officer No. 11,
District No. 1239-1639

DEC 6 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

Leroy H. Phillips

Licensed Embalmer No. *1898*

P. O. Address *Stouffville*

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.

