

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.

Registration District No. 102

Primary Registration District No. 4062

Registrar's No. 31

1. PLACE OF DEATH:  
 (a) County CALLAWAY  
 (b) City or town ANXWASSE 2  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community LIFE  
years, months or days

3. (a) PRINT FULL NAME William Thomas Scholt 400  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife MARIA GERERUDE 6. (c) Age of husband or wife if alive 85 years  
 7. Birth date of deceased MAR 11 1850  
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 14 If less than one day \_\_\_\_\_  
hr. min.

9. Birthplace CALLAWAY Co. MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER 0

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name MILTON, Scholt 1  
 13. Birthplace KENTUCKY  
(City, town, or county) (State or foreign country)  
 14. Maiden name SARAH Chad Hughes  
 15. Birthplace CALLAWAY Co. MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature B. B. Scholt  
 (b) Address Anxwasse, Mo.

17. (a) BURIAL (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation LIBERTY

18. (a) Signature of funeral director Hughes Marburn  
 (b) Address Anxwasse, Mo. 1105

19. (a) Dec 26-39 (b) L. B. Nichols  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County CALLAWAY  
 (c) City or town ANXWASSE  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec day 25  
 year 1939 hour 5 minute 05 P. M.  
 21. I hereby certify that I attended the deceased from Dec 25  
1939 to Dec 25, 1939;  
 that I last saw h alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage probably from the stomach was first response received  
 Due to senility  
 Due to \_\_\_\_\_

Other conditions 113  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury  
 23. Signature L. B. Nichols (M. D. or other) \_\_\_\_\_  
 Address Anxwasse Mo Date signed Dec 26 1939

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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..... *Hughes Manpin*.....  
Licensed Embalmer No..... *2358*.....  
P. O. Address..... *AuxVasse 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.**