

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

Do not use this space.

FILED MAR 11 1940

1. PLACE OF DEATH

County..... Cole Registration District No. 213
 Township..... Jefferson Primary Registration District No. 3014
 City..... Jefferson City, Mo. St. Marys Hosp. St. _____ (Ward)

File No. 6363
 Registered No. 37

2. FULL NAME Elizebeth Amelia Schoch

(a) Residence, No. _____ St., 0 Ward. Russellville, Mo.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John M. Schoch

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 5th 1905
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
34 3 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Lohman, Mo. (STATE OR COUNTRY) Cole, Co. 0

MOTHER FATHER 13. NAME Henry Strobel
 14. BIRTHPLACE (CITY OR TOWN) Germany. (STATE OR COUNTRY) 6

15. MAIDEN NAME Catherin Woehrer
 16. BIRTHPLACE (CITY OR TOWN) Lohman, Mo. (STATE OR COUNTRY) 0

17. INFORMANT Carl Strobel (ADDRESS) Russellville, No.

18. BURIAL, CREMATION, OR REMOVAL PLACE Russellville Luth. Cem. DATE Feb. 16, 40

19. UNDERTAKER Hugh H. Schuchel (ADDRESS) Russellville, Mo.

20. FILED 2-15- 1940 D. W. Strobel Registrar. (Address) Jefferson City, Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/14/1940 1940

22. I HEREBY CERTIFY, That I attended deceased from February 14, 1940 to February 14, 1940
 I last saw him/her alive on Feb 14, 1940 Death is said to have occurred on the date stated above, at 5:45 P.M.

The principal cause of death and related causes of importance were as follows:
Embolism (Right Axillary artery) 2-12-40
 Date of onset
 Other contributory causes of importance: 14.5
Peripneumonia 14th day

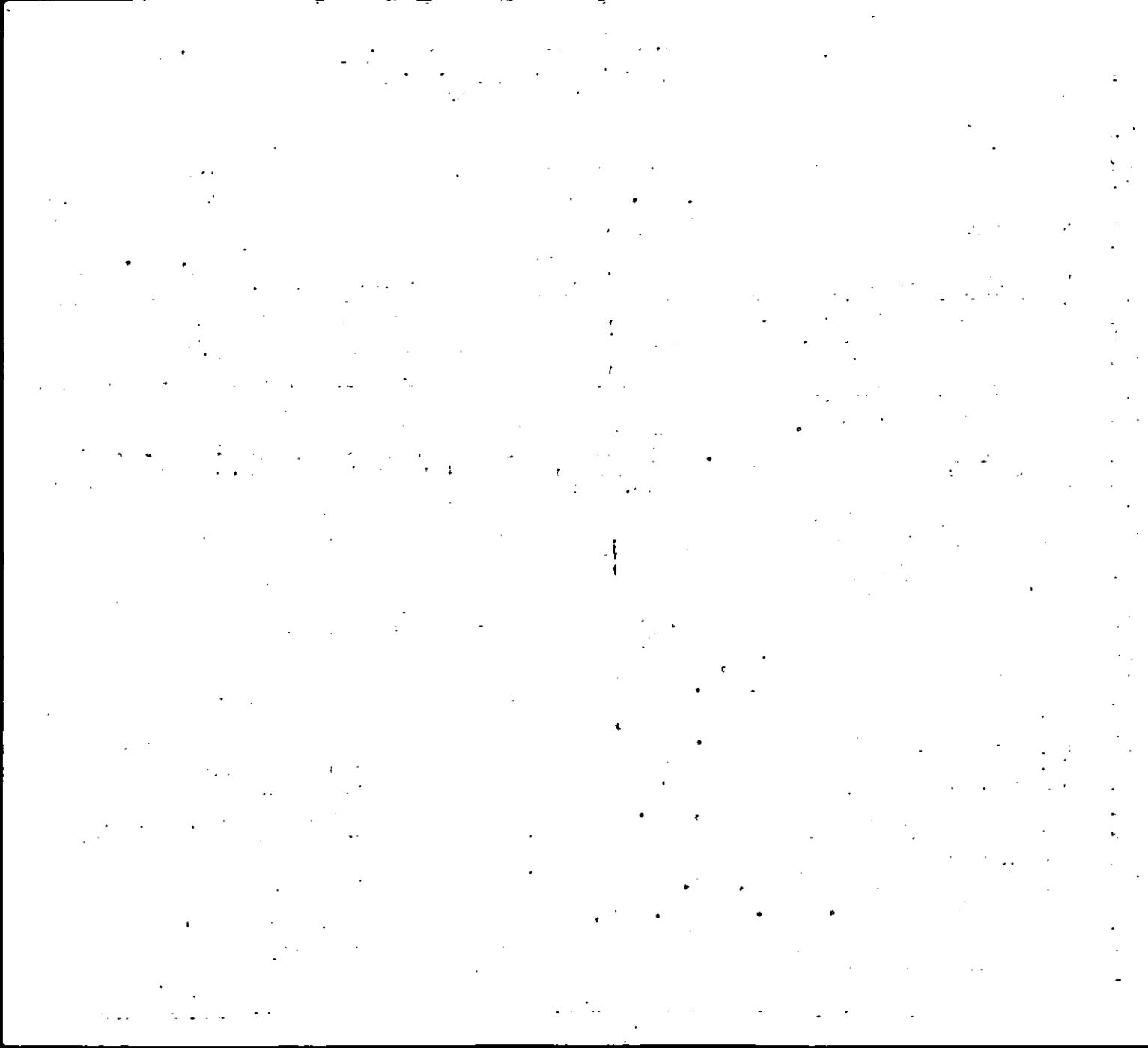
Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

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 Julian A. Osman M. D. (Signed) _____ (Address) Jefferson City, 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.



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *6363*

Registration District No.

Primary Registration District No.

Registrar's No. *27-*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH:

(a) County *Cole*

(b) City or town *Jefferson City*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *St. Marys Hosp.*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME *Elizabeth A. Schoch*

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M-*

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace.....
(City, town, or county) (State or foreign country)

{ 14. Maiden name.....

{ 15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(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.

20. DATE OF DEATH: Month *Feb.* day *14* - year *70*
hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw him alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death: *Embolicism Pt. splenic artery*

Due to: *Normal delivery* 149

Due to: *Purpura 14 Ds.*

Other conditions (include pregnancy within months of death):
Was delivered in country admitted to hospital in

Major findings: *terminal cancer of gangrene R. arm*

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 *James A. Harrison* (M.D. or Other)
Address *Jeff. City Mo* Date signed.....

SUPPLEMENTARY

