

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

10550
Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 130
 (b) Township Wessel Primary Registration District No. 5175
 or Chaffee, P.D. 3
 (c) City Chaffee, P.D. 3 Street No. 2 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 John Theodore Schreckenberg
 (a) Residence, No. Leopold, Mo. 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) widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anne Nebor
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 7 - 1863
 7. AGE YEARS 77 MONTHS 7^o DAYS 19 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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.
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Glen Allen, Missouri, Mo.
 FATHER 13. NAME Joseph Schreckenberg, Mo.
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Old Country, S.
 MOTHER 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Mo.
 17. INFORMANT (ADDRESS) Joseph Frankle, Chaffee, Mo.
 18. BURIAL, CREMATION, OR REINTERMENT PLACE Leopold DATE March 28, 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) None
 20. FILED Apr 1, 1940 Mrs Wm Stuckler (Address) Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1940
 22. I HEREBY CERTIFY, That I attended deceased from March 15, 1940, to March 26, 1940
 I last saw him alive on 18th, 1940. Death is said to have occurred on the date stated above, at 12⁴⁵ m.
 The principal cause of death and related causes of importance were as follows:
Arteriosclerosis
Central Hemiplegy
 Date of onset
 Other contributory causes of importance: high blood pressure.
 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 so, specify W.D. Savant
 (Signed) Allen M. M.D.

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.

5010-10-38 I X16005

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 130

Primary Registration District No. 5178

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Welsh Inn
(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 _____ (Specify whether _____)
years, months or days

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

3. (a) PRINT FULL NAME

John Theodore Schreckenberg

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Sept 7 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) May 4 1940 (b) Mrs Wm Stuckley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 26 year _____ 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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(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) (c) Means of injury _____

23. Signature W.W. Devault (M. D. or other) _____

Address Allenville, Mo Date signed _____

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10550

Registration District No. 130

Primary Registration District No. 2175-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Welsh
(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 _____ years, months or days

3. (a) PRINT FULL NAME

John Theo. Schreckenberger

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wed
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
	<u>77</u>	<u>7</u>	<u>19</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 14-40 (b) Mrs. M. Stickle (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 Mar day 26 year 1940 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 W. W. Rowlett (M. D. or other) _____

Address Allenrille Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

COPYING ON THIS FORM WILL MAKE A PERMANENT RECORD