

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

H-9 5-17-39 I 41951

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. 796

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Saline County
 (b) City or town Marshall Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Fitzgibbon Marshall Mo 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 Mon
 (Specify whether
 In this community yes
 years, months or days 11 11)

8. (a) PRINT FULL NAME Harmon B. Schlackelmont

8. (b) If veteran, name war yes 8. (c) Social Security No. 7

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased April 7-1919
 (Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation Bakery helper

11. Industry or business _____

MOTHER FATHER { 12. Name Harmon Schlackelmont
 13. Birthplace Concordia Mo.
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Angie Bohman
 15. Birthplace Concordia Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Alfred Schlackelmont
 (b) Address Concordia Mo

17. (a) Concordia (b) Date thereof Mar 14, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Pauls Cemetery

18. (a) Signature of funeral director Bierberg & Coys
 (b) Address Concordia Mo

19. (a) 3-14-40 (b) Mary Kent
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
 (c) City or town Concordia, Mo
 (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 3 day 13
 year 1940 hour 10:40 minute _____ P. M.

21. I hereby certify that I attended the deceased from 3-13-40
 _____, 19____, to 3-13-40, 19____;
 that I last saw him alive on 3-13-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death traumatic injury to chest. Internal rupture of stomach + rib fracture
 Due to Car. wreck at Concordia, Missouri.
 Due to Internal hemorrhage + chest internal hemorrhage + chest

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: None
 Of operations _____
 Of autopsy None

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Car wreck
 (b) Date of occurrence 3-13-40
 (c) Where did injury occur? Concordia, Missouri, Highway 40
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
no
 While at work? no (Specify type of place) (e) Means of Injury _____
 23. Signature Chas L Purson (M. D. or other) MD
 Address Street Springs Mo Date signed 3-14-40

Duration 2 hours
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

2/6/20
2/9/20

RECEIVED
District Health Officer No. 8,
District File Number 4-9-40
Date Filed

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 E. S. Frerking & J. C. Voigt

2959 1511
Licensed Embalmer No.....

P. O. Address Concordia 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12529
Registrar's No. 49

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 796

Primary Registration District No. 3038

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(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)

3. (a) PRINT FULL NAME

Herman J Schlechelman

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 S

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 20 Months 11 Days 6

If less than one day _____ hr _____ min.

9. Birthplace _____

(City, town, or county)

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) _____ (Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

(b) _____

(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.

MEDICAL CERTIFICATION

20. TIME OF DEATH: Month 3 day 13
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 Traumatic injuries to chest Internal injuries Fracture of sternum and all ribs
Due to Car wreck ✓
Collision with another car ✓
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
120

Major findings Internal Hemorrhage
Shock
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) Accident
(b) Date of occurrence 3-13-40
(c) Where did injury occur? Highway #40 Emma, Mo
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway #40
(Specify type of place) _____
While at work _____ (e) Means of injury _____
23. Signature Chas R Pearson (M. D. or other)
Address Swick Springs, Mo

SUPPLEMENTAL

1940

S-12529