

Registration District No. 296

Primary Registration District No. 4180

Registrar's No. _____

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.

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Union
(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 years, months or days)

3. (a) PRINT FULL NAME Bernhard Henry Schreiber
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Louisa W. Schreiber 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. II 1852
(Month) (Day) (Year)

8. AGE: Years 82 Months 6 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Carpenter

11. Industry or business _____

12. Name Frank Schreiber

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

14. Maiden name Mary Wibbelmann

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

16. (a) Informant's own signature Ernest Seaman

(b) Address Union, Missouri

17. (a) Burial (b) Date thereof 4-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director W. H. Howe

(b) Address Union, Missouri

19. (a) 4-29-40 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Franklin
 (c) City or town Union
(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 April day 25
 year 1940 hour 8:05 a.m. minute _____ M.

21. I hereby certify that I attended the deceased from 2/25/39
 _____, 19____, to 4/25, 1940
 that I last saw him alive on 4/22, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Progressive cardiac failure due to hypertension
 Duration Approx 4 yrs

Due to Arterio-sclerosis (generalized)
Hypertension

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? 854
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. S. Depprich (M. D. or other) _____
 Address Union, Mo Date signed _____

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.....

W. H. Howe

Licensed Embalmer No. *3175*

P. O. Address *Union, 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.

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 14819

Registration District No. 296

Primary Registration District No. 4180

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Union
(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)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH Month apr day 25 year 1946 hour _____ minute _____ M.

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

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 _____

8. AGE: Years 82 Months 6 Days 14 If less than one day _____ hr. _____ min.

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

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)
(Burial, cremation, or removal)

18. (a) Signature of funeral director _____ (b) Address _____

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

19. (a) 4-27-40 (b) Lucas T. Hawick
(Date received local registrar) (Registrar's signature)

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 M. S. Weffersich (M. D. or other) _____
Address Union Mo Date signed _____

SUPPLEMENTARY

S-14819