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

18840

Do not use this space.

JUN 5 1940

1. PLACE OF DEATH
(a) County Lafayette 2 Registration District No. 464
(b) Township or City 0 Primary Registration District No. 4275 Registered No. 25-
(c) Mayview. Mo. (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 532 Dorthy M. Schmutz- (Unsicker)
(a) Residence, No. 35 yrs St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam R. Schmutz

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-3-1871

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
68	5	25	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) Tre Mont Ill. 1

FATHER
13. NAME Christian Unsicker 6
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER
15. MAIDEN NAME Minnie Kahler 6
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Mrs. Martin Sanders Mayview. Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mayview. Mo. DATE 4-30-1940, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hoefer & Meinershagen Higginsville. Mo. 4/1

20. FILED 4-29 1940 Mrs E. M. Goodwin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-28-1940, 19

22. I HEREBY CERTIFY, That I attended deceased from Apr. 27 -, 1940, to Apr. 28 -, 1940
I last saw her alive on Apr. 28 -, 1940. Death is said to have occurred on the date stated above, at 12:10 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Uremia	2

Other contributory causes of importance:
Unknown

Name of operation No Date of
What test confirmed diagnosis? None 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? No
If so, specify
(Signed) Jno B Willis, M. D.
(Address) Mayview. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

132

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-14-40

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 me, Registered Apprentice No. working under my personal supervision.

Signed Roy F Wiegers

Licensed Embalmer No. 2883

P. O. Address Higginsville. MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18840

Registration District No. 464 Primary Registration District No. 4275 Registrar's No.

1. PLACE OF DEATH
(a) County: Lafayette
(b) City or town: Mayview
(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)
In this community

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: Dorothy M. Schmutz
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 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 25 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 (Father)
13. Birthplace (City, town, or county) (State or foreign country) (Father)
14. Maiden name (Mother)
15. Birthplace (City, town, or county) (State or foreign country) (Mother)
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 28 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	
# Examined woman 1 hr before death. Autopsy refused. M. M. D.	
Due to	
Due to	
Other conditions: Unknown (Include pregnancy within 3 months of death)	
Major findings: Of operations: None.	
Of autopsy: None	

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: Jno. B. Willis (M. D. or other)
Address: Mayview Mo. Date signed

SUPPLEMENTARY

S-18840