

Registration District No. 4

Primary Registration District No. 5005

Registrar's No. 152

1. PLACE OF DEATH: **DECEASED JUL 17 1940**
 (a) County Adair
 (b) City or town Rural Benton Twp. 7
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
R. F. D. # 6
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 66 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Adair
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Benton Twp. R.F.D.# 6
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 17
 year 1940 hour 5:00 PM minute _____ M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife William Scheer
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 18 1846
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw her alive on June 17 1940 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
94 0 29 hr. _____ min.

Immediate cause of death
Old age & Hypertrophy of heart
 Due to _____
 Due to _____

9. Birthplace Wheeling W. Virginia
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) 95 B²

11. Industry or business Home
 12. Name Martin Gerhold
 13. Birthplace IK Germany
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Arthur J. Jorgensen
 (b) Address Kirkville, Mo.
 17. (a) Burial (b) Date thereof 6-19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation Millard Cemetery
 18. (a) Signature of funeral director Davis Funeral Home
 (b) Address Kirkville, Missouri
 19. (a) June 17/40 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (D. or other) _____
 Address _____ Date signed _____

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

KX1492

RECEIVED

District Health Officer No. 10

District File Number 7-40-1435

Date Filed JUL 15 1940

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 Harold H. Hejzal

Licensed Embalmer No. 4076

P. O. Address Kirkville, 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. **21042**
Registrar's No. **152**

Registration District No. **1**

Primary Registration District No. **2**

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

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Centon T.P.**
(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:
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lucinda Scheer**

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 **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)

8. AGE: Years **94** Months **0** Days **29**
If less than one day, h. 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 **Wink** (City, town, or county) (State or foreign country)

15. Birthplace **Wink** (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) **July 31, 1940** (Date received by local registrar) (b) **Spencer L. Treeman** (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. DATE OF DEATH: Month **June** day **17**
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 **F. B. Farrington** (M. D. or other)

Address **Keiserville Mo** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

