

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Walsh

38699

State File No.

906

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
601 Normal
(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

3. (a) PRINT FULL NAME Charles R. Schofield

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

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

6. (b) Name of husband or wife Alice B. Schofield 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased April 1 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 7 If less than one day hr. min.

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

10. Usual occupation Retired Painter and Paper Hanger

11. Industry or business _____

MOTHER FATHER { 12. Name George B. Schofield

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

14. Maiden name Carry Schofield

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

16. (a) Informant Geo Schofield

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Nov. 10 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. H. Hohmeyer

(b) Address Springfield, Mo.

19. (a) 11-10-40 (b) W. E. Handley, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 601 Normal
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
year 1940 hour 7 minute 40 a.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him alive on 11-5, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral hemorrhage
Due to arterio sclerosis
Duration 3 days

Other conditions Paranasal of Right side of face & mouth
Due to 45
Duration 6 to 8 yrs

Major findings: primary of mouth
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) (e) Means of injury _____

23. Signature W. E. Handley (M. D. or other) _____
Address Springfield Mo Date signed 11/9/40

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

SEP 8 1952

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 *L. D. Lorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield, 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.

X