

Registration District No. 757 Primary Registration District No. 7036 Registrar's No. 70

1. PLACE OF DEATH  
(a) County St. Charles  
(b) City or town St. Charles  
(c) Name of hospital or institution St. Joseph's  
(d) Length of stay: In hospital or institution 19 days  
In this community 19 days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County St. Charles  
(c) City or town New Mills Mo  
(d) Street No. Rural  
(e) If foreign born, how long in U. S. A. 1 years

3. (a) PRINT FULL NAME Elizabeth Schroeder

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month April day 16 year 1941 hour 10 minute 30 A.M.

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Widowed

21. I hereby certify that I attended the deceased from March 20, 1941, to April 16, 1941, that I last saw her alive on Apr. 16, 1941, and that death occurred on the date and hour stated above.

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

Immediate cause of death  
Coronary infarct - Myocardial

7. Birth date of deceased May 28 1864

Due to Chronic myocarditis, Bacillus coli blood and

8. AGE: Years 76 Months 11 Days 19 hr. min.

Due to liver, jaundice, Hypertension,

9. Birthplace Frenchburg Mo (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Home duties

Major findings: Of operations Bacillus coli blood and Bone lesions, Gall stones  
Of autopsy

11. Industry or business

12. Name Phillip Klippel

13. Birthplace West Korb Mo (State or foreign country)

14. Maiden name West Korb

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

16. (a) Informant Mrs. Gus Amelting (b) Address New Mills Mo

17. (a) Burial (b) Date thereof Apr 19 41 (c) Place: burial or cremation New Mills Mo

18. (a) Signature of funeral director (b) Address (c) Date received local registrar 4-16-41 (d) Registrar's signature

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature Vincent A. Schumaker (M. D. or other) Address St. Charles, Mo. Date signed 4-18-41

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

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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

*T. C. Fitzmaurice*

Licensed Embalmer No. *2711*

P. O. Address *Kentzville, Pa.*

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13-680  
Registrar's No. 70

Registration District No. 757 Primary Registration District No. 3086

1. PLACE OF DEATH

(a) County St Charles  
(b) City or town St Charles  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Elizabeth Schroeder

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	Months	Days	If less than one day
	<u>76</u>	<u>11</u>	<u>19</u>	_____ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 16  
year 1941 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 Cardiac Infarct migs  
Cardiac

Due to Chr migs Carditis  
Due to Carcinoma Gall bladder  
and liver jaundice  
Other conditions Hypertension  
(Include pregnancy within 9 months of death)

Major findings: Carcinoma liver  
Of operation and gall bladder  
Of autopsy Gall stones  
Primary Carcinoma Gall Bladder

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 Wm A Schroeder (M. D. or other) MD  
Address St Charles Mo Date signed 6/21/41

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

SUPPLEMENTARY

S-15660