DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 20 1941

Registration District No. 449

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31893

Primary Registration District No. 4267

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon R.P. Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wallace Memorial Hospital, Lebanon
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 hours (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 6

(c) City or town Kirkwood 4
(If outside city or town limits, write "RURAL")

(d) Street No. 3
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Herbert E. Scheidegger

3. (b) If veteran, name war

3. (c) Social Security No. 494-03-3258

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Shirla Donaldson

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased May (Month) 30 (Day) 1915 (Year)

8. AGE:

Years	Months	Days	If less than one day
26	4	11	hr. min.

9. Birthplace Kirkwood Mo (City, town, or county) ( ) (State or foreign country)

10. Usual occupation Gas & Oil

11. Industry or business Filling Station

FATHER
12. Name Albert P Scheidegger
13. Birthplace Herman Mo (City, town, or county) ( ) (State or foreign country)

MOTHER
14. Maiden name Francis M. Baumker
15. Birthplace Washington Mo (City, town, or county) ( ) (State or foreign country)

16. (a) Informant Shirla Donaldson Scheidegger

(b) Address Kirkwood Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/13/41 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter & Paul Cemt.

18. (a) Signature of funeral director Louis H. Bopp

(b) Address Kirkwood Mo.

19. (a) 10-11-41 (Date received local registrar) (b) J. A. McComb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 10th
year 1941 hour 5 minute 30 p. M.

21. I hereby certify that I attended the deceased from 1 A.M. - Oct 9, 1941, to Oct. 10, 1941;
that I last saw him alive on Oct 10 (4:59 P.M.) 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: basal & frontal skull fractures	41 hrs.
Due to: Car accident	—
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) accident.

(b) Date of occurrence Oct. 9, 1941 OTB

(c) Where did injury occur? Lebanon, Laclede, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 3 mi East on Hiway #66. (Specify type of place)

While at work? no (e) Means of injury Car accident

23. Signature James L. Hope (M. D. or other)

Address Lebanon, Mo Date signed 10/11/41.

4:57

(Licensed Embalmer's Statement on Reverse Side)

NOV 6 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

.2B
21-41
K29280

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STANDARD CERTIFICATE OF DEATH

State File No. 31893

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

1. PLACE OF DEATH:
(a) County: Laclede
(b) City or town: Lebanon
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Herbert E. Scheidegger
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
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: May (Month) 30 (Day) 1916 (Year)

8. AGE: Years 26 Months 4 Days 17 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (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) 11-22-41 (Date received local registrar) (b) Ja M Cowell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 19 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: basal & frontal skull fracture — Duration
Due to: Car accident
Due to:
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations: 1 no C-S
Of autopsy: 2 no

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): accident
(b) Date of occurrence: Oct. 9 - 1941
(c) Where did injury occur? Laclede (City or town) Mo. (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Our home (Specify type of place) (e) Means of injury: Car
While at work? not

23. Signature: J. E. Hope (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-31893 1941