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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 21 1941

Registration District No. 7603

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6001

State File No. 32384

Registrar's No. 152

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

1. PLACE OF DEATH:
(a) County: ST. CHARLES
(b) City or town: O'FALLON RURAL
(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: 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: ST. CHARLES 092
(c) City or town: O'FALLON RURAL
(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.? — 0 years.

3. (a) PRINT FULL NAME: SOPHIA SCHAEFFER
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~~: 1
6. (b) Name of husband ~~or wife~~: LOUIS SCHAEFFER
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: OCTOBER (Month) 14 (Day) 1877 (Year)

8. AGE: Years	Months	Days	If less than one day
63	11	7	— hr. — min.

9. Birthplace: ST. CHARLES (City, town, or county) MO. (State or foreign country) 0
10. Usual occupation: HOUSE WORK
11. Industry or business: —
FATHER 12. Name: WEHMEYER
FATHER 13. Birthplace: — (City, town, or county) GERMANY (State or foreign country) 4
MOTHER 14. Maiden name: GRAU
MOTHER 15. Birthplace: — (City, town, or county) GERMANY (State or foreign country) 4
16. (a) Informant: LOUIS SCHAEFFER
(b) Address: O'FALLON MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 9 24 '41 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~: O'FALLON MO.
18. (a) Signature of funeral director: Ed Kuehly
(b) Address: O'Fallon Mo
19. (a) 9-22-41 (Date received local registrar) (b) Ed Kuehly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 21 year 1941 hour 4 minute 30 P.M.
21. I hereby certify that I attended the deceased from June, 1939, to Sept. 21, 1941; that I last saw her alive on Sept. 21, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	4 yrs.
Due to	
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)
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Nicholas J. Honeck (M. D. ~~or other~~)
Address: O'Fallon Mo Date signed 9-22-41

(Licensed Embalmer's Statement on Reverse Side)

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 E A Keithly

Licensed Embalmer No. 8 r r

P. O. Address Fallon 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.

. No. 2B
—8-21-41
PI X29288

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. 32384

Registration District No. 760B Primary Registration District No. 6001 Registrar's No.

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town Rural
(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 Sophia Schaeffer
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 72 years
7. Birth date of deceased Oct 14 1877 (Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 7 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) (Date received local registrar) (b) E A Keithly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 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	
Due to	
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)
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY