

FILED MAR 3 1942
Registration District No. **25**

Primary Registration District No. **3009**

Registrar's No. **13**

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 1 da years, months or days (Specify whether)

3. (a) PRINT FULL NAME John Schlenker Jr.
3. (b) If veteran. name war. _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Single
6. (b) Name of husband or wife. _____ 6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased November 29 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 1 12 hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name John Schlenker
13. Birthplace Du Quion Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Earnel Hartle
15. Birthplace Cape Girardeau Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant John Schlenker
(b) Address Fornfelt, Mo.

17. (a) Burial (b) Date thereof Jan. 12 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jonesboro, Ill.

18. (a) Signature of funeral director L. L. Heman
(b) Address Cape Girardeau, Mo.

19. (a) 1-12-42 (b) G. W. Phelps
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 100
(c) City or town Fornfelt 2
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11
year 1942 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 9
1942 to Jan 10 1942
that I last saw him alive on Jan 9 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia - Catarrhal Duration

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? _____

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

23. Signature D. M. Murphy (M. D. or other) _____
Address Cape Girardeau Date signed 1-12-42

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

1614

RECEIVED

District Health Officer No. 4
District File Number 242-156
Date Filed 2-10-42

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. L. Haman
Licensed Embalmer No. 2863
P. O. Address Cape Esir, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6217**
Registrar's No.

Registration District No. **125**

Primary Registration District No. **3009**

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

1. PLACE OF DEATH: **Cape Girardeau**
(a) County.....
(b) City or town..... **Cape Gir**
(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 **John M. Schlenker**
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.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years

7. Birth date of deceased **Nov 29 1945**
(Month) (Day) (Year)

8. AGE: Years **—** Months **1** Days **29** If less than one day, min.
h. min.

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

10. Usual occupation.....
11. Industry or business.....

MOTHER FATHER { 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.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (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 **Jan**, day.....
year **1942** hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia Catarrhal**
Duration.....

Due to **No complications**
Due to.....

Other conditions..... (Include pregnancy within 3 months of death) **107**

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other)
Address..... Date signed.....

