S. No. 2
—9-4-41
5-17-39
PI X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 11 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36611

Registration District No. 26 Primary Registration District No. 5090 Registrar's No. 33

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: [illegible] P. O. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution [illegible] (Specify whether
In this community 64 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Bates 7
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? none (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William John Schmidt
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 single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. (Month) 23 (Day) 1868 (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	2	8	hr. min.

9. Birthplace (City, town, or county) Germany (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Carl Schmidt
13. Birthplace (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Wilhelmina Starr
15. Birthplace (City, town, or county) Germany (State or foreign country)
16. (a) Informant Albert Fischer
(b) Address Appleton City Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Prairie City Zion Cemetery
18. (a) Signature of funeral director Oscar Eckhoff
(b) Address Appleton City Mo.
19. (a) 12/3/42 (Date received local registrar) (b) Mrs. O. W. Farrow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1 year 1942 hour 12 minute 00 P.M.
21. I hereby certify that I attended the deceased from Oct. 1, 1942 to Dec. 1, 1942 that I last saw him alive on Dec. 1, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	5 days
Due to Brights Disease	1 yr.
Due to Myocarditis	5 yrs.
Other conditions Prostatic adenoma (Include pregnancy within 3 months of death)	5 yrs.

Major findings:
Of operations none Performed
Of autopsy none Performed

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 0
23. Signature M. O. Bjerke (M. D. or other)
Address Rockville, Mo. Date signed 12/2/42

1304 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 12-42-1275
Date Filed 12-7-42

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 Oscar Eckhoff

Licensed Embalmer No. 3942

P. O. Address Appleton City Mo

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

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

V. S. No. 2B
10M—8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36611

Registration District No. 25 Primary Registration District No. 5090 Registrar's No. 33

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

1. PLACE OF DEATH:

(a) County Baten

(b) City or town Prairie Twpt. rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Prairie Township, rural
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether
In this community 64 yrs.
years, months or days)

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 Wm John Schmidt

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 S

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

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

7. Birth date of deceased Sept (Month) 23 (Day) 1868 (Year)

8. AGE:

Years	Months	Days	If less than one day
74	2	6	hr. ..... min.

9. Birthplace ..... (City, town, or county) Germany (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) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 1
year 1942 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... 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

S-36611