

No. 2
4-13-40
5-17-39
P-1 X23159

On File 37131
State File No. _____
Registrar's No. 847

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED DEC 5 1942

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 847

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
815 W. Dale /
(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 **4 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield,**
(If outside city or town limits, write "RURAL")
(d) Street No. **815 W. Dale**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRINT FULL NAME **Sophia Schweke**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **November** day **26th,**
- year **1942** hour **3:30** minute _____ A. M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Henry F. Schweke**
6. (c) Age of husband or wife if alive **Deceased** years
7. Birth date of deceased **August 8, 1864**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **11-1**, 19**42**, to **11-26**, 19**42**
that I last saw h. **alive** on **11-25**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of Stomach** Duration **1 yr.**

8. AGE: Years **78** Months **3** Days **18**
If less than one day _____ hr. _____ min.

Due to _____
Due to _____

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) **46 lb**

10. Usual occupation **In Home**

11. Industry or business **In Home**

12. Name **Unknown**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Russell E. Schweke**
(b) Address **Springfield, Missouri**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **Nov. 26, 1942**
(Month) (Day) (Year)
(c) Place: burial or cremation **St. Louis, Missouri**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**
Springfield, Missouri
(b) Address _____

(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 _____

19. (a) **11-27-42** (Date received local registrar) (b) **S. W. Handley** (Registrar's signature)

23. Signature **May S. [unclear]** (M. D. or other) **M.D.**
Address **Springfield Mo** Date signed **11-27-42**

(Licensed Embalmer's Statement on Reverse Side)

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

39
2
6

39
2
6

0

1 yr.

46 lb

107

4

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 Lewis G. Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.

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