DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1942

Registration District No. 109

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37467

Primary Registration District No. 0667

Registrar's No.

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

1. PLACE OF DEATH:
(a) County: LINCOLN
(b) City or town: RURAL (BEDFORD TWP)
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: LINCOLN
(c) City or town: RURAL (BEDFORD TWP.)
(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: CAROLINA ANN SCHULZE

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: MARRIED

6. (b) Name of husband or wife: GUST. W. SCHULZE

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

7. Birth date of deceased: JANUARY (Month) 20 (Day) 1869 (Year)

8. AGE: Years 73 Months 8 Days 26 If less than one day ____ hr. ____ min.

9. Birthplace: LINNS MILL (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation: HOUSEWIFE

11. Industry or business: OWN HOME

MOTHER FATHER
12. Name: JOHN H. SCHEER
13. Birthplace: ✓ (City, town, or county) GERMANY (State or foreign country)

MOTHER
14. Maiden name: MARY SCHLOEMANN
15. Birthplace: ✓ (City, town, or county) GERMANY (State or foreign country)

16. (a) Informant: Mr. Gust W. Schulze
(b) Address: Troy, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 19 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: ZOAR Church Lincoln Co Mo

18. (a) Signature of funeral director: Kamper Funeral Home
(b) Address: Troy, Mo.

19. (a) Nov. 16/42 (Date received local registrar) (b) Mrs. Floy Jackson (Registrar's signature)

1185 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 16 year 1942 hour 10 minute 05 A.M.

21. I hereby certify that I attended the deceased from Oct 5 1942 to Oct 16 1942; that I last saw him alive on ____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: (a) Hypostatic Pneumonia — Duration 3 days
Due to: (b) Senility —
(c) Arterio-sclerosis —
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: Jos. Leberich (M. D. or other)
Address: Troy, Mo. Date signed Oct 16/42

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.....Joseph J. Marsh

Licensed Embalmer No.....3932

P. O. Address.....Troy, 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.

. S. No. 2B
0M—8-21-41
I 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. 37467

Registration District No. 179 Primary Registration District No. 5667 Registrar's No.

1. PLACE OF DEATH:
(a) County: Lincoln
(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: Caroline A Schulze
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 years
7. Birth date of deceased: Jan (Month) 20 (Day) 1866 (Year)
8. AGE: Years 73 Months 8 Days 16 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (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) (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) Nov. 15-41 (Date received local registrar) (b) Mrs Hay Jackson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 16 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.

Immediate cause of death: Hypostatic Pneumonia (Lobar) — Duration 3 days
Due to (2) Senility
Due to (3) arteriosclerosis
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: Jas. C. Leach (M. D. or other)
Address: Troy Mo. Date signed

SUPPLEMENTARY