

FILED APR 14 1943

Registration District No. **163**

Primary Registration District No. **5596**

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

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Rural Valle
(c) Name of hospital or institution:
Route 2, DeSoto
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community 30 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jefferson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2 DeSoto
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME OLLIE SCHMICK

3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife William C. Schmick
6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept. 23 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>5</u>	<u>18</u>	hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER {
12. Name William Connors
13. Birthplace ? ?
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hockman
15. Birthplace ? W. Va.
(City, town, or county) (State or foreign country)

16. (a) Informant W. Schmick
(b) Address R.R. No 2 - DeSoto Mo.

17. (a) Burial (b) Date thereof March 13, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DeSoto Mo. (City)

18. (a) Signature of funeral director Lee Mothershead
(b) Address DeSoto, Mo.

19. (a) 3-13-43 (b) Fun. Geneser
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1943 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 3/8/43
19 to 3/11/43 19
that I last saw her alive on 3/11/43 19
and that death occurred on the date and hour stated above.

Immediate cause of death
acute Obstruction of Bowels
Due to Growth of tumor in R. Hypochondriac Region
Due to _____

Duration
3 da.
1 1/2 yrs.

Other conditions (Include pregnancy within 3 months of death) _____

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 J. A. Elders (M. D. or other) MD
Address De Soto Mo Date signed 3/12/43

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 *Jess Mothershead*
Licensed Embalmer No. *3531*
P. O. Address *Edato m*

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. 10626
Registrar's No. 20

Registration District No. 163

Primary Registration District No. 6596

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town resid
(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 Ollie Schmick

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 Sept 23 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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 March year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death acute obstruction of bowels Duration 3 days

Due to throat or tumor in R hypochondriac region 1 1/2 yrs.

Due to Benign origin based on previous clinical symptoms.

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? _____

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

23. Signature J.A. Elders (M. D. or other) MD

Address _____ Date signed 4/13/43

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

SUPPLEMENTARY

MOTHER FATHER

S-10626