

S. N. 4-8-43 5-17-39 I X37823

State File No.

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 125-

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
West Excelsior, St. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no.
(Specify whether)
 In this community 63 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay ²⁴
 (c) City or town Excelsior Springs ¹
(If outside city or town limits, write "RURAL")
 (d) Street No. West Excelsior St.
(If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME SUSAN SHRIENER

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Fred Shriener 6. (c) Age of husband or wife if alive 3 years
 7. Birth date of deceased Aug 3rd 1853
(Month) (Day) (Year)

8. AGE: Years 91 Months 1 Days 15 If less than one day hr. min.

9. Birthplace Grundy Co. Mo?
(City, town, or county) (State or foreign country)

10. Usual occupation at Home

11. Industry or business ←

MOTHER FATHER { 12. Name ? mason
 { 13. Birthplace unknown unknown
(City, town, or county) (State or foreign country)
 { 14. Maiden name unknown
 { 15. Birthplace unknown unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Lee Brumby
 (b) Address 2205 Garfield, Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof 9/20/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Crown Hill, Excelsior Springs

18. (a) Signature of funeral director Therese Hope
 (b) Address Excelsior Springs, Mo

19. (a) 9-20-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18th
 year 1944 hour 11 minute 34 P.M.
 21. I hereby certify that I attended the deceased from June
3, 1944 to Sept 18, 1944
 that I last saw her alive on Sept 18, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Traemia Duration: 10 Days
 Due to Chronic Interstitial Nephritis
 Due to Arterial Sclerosis
 Other conditions age - 91
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: none made
 Of operations: none made
 Of autopsy: none made
 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) _____
 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)
 Means of injury car
 23. Signature John S. Trach M.D. or other _____
 Address Excelsior Springs Date signed 9/20/44

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

RECEIVED

Health Officer No. 8.

District File Number

Date Filed

10-10-44

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

Jack H. Moles

Licensed Embalmer No. 3296

P. O. Address

Edulvis Apgo 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2027

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 125

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

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs, Mo
(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 _____ (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 Susan Shuerer

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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Aug 3 1893
(Month) (Day) (Year)

8. AGE: Years 91 Months 1 Days _____ If less than one day _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Registrar's signature) Mrs Sadie Redman
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 8 Year 1944 hour _____ minute _____ M.

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

Duration _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

3075b