

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10855
Registrar's No. 46

FILED APR 18 1945
Registration District No. 200

Primary Registration District No. 6276

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

1. PLACE OF DEATH

(a) County Vernon

(b) City or town Rural Washington Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. No. 3.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 yrs. 4 mo 22 d
(Specify whether years, months or days)

In this community Same time

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 109

(c) City or town St. Louis City.
(If outside city or town limits, write "RURAL")

(d) Street No. City Parkman
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louise Schadel

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 Divorced

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

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>-</u>	<u>-</u>	hr. min.

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

10. Usual occupation Housework

11. Industry or business own home

MOTHER FATHER

12. Name _____

13. Birthplace unknown
(State or foreign country)

14. Maiden name _____

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

16. (a) Informant Hospital Records

(b) Address Nevada Mo.

17. (a) Burial (b) Date thereof 3-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Jerry General Home

(b) Address Nevada Mo.

19. (a) 3-17-45 (b) Fred B. Burch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 1945 hour 7:30 minute P. M.

21. I hereby certify that I attended the deceased from 12-6-1944
19____ to 3-15-1945 19____

that I last saw her alive on 3-15-1945 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Psychosis with Duration
Convulsive Seizures
(Epilepsy)

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations 85

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?
(Specify type of place) _____

While at work? _____ (e) Means of injury C

23. Signature F B Burch (M. D. or other) _____
Address Nevada Mo Date signed 3-15-45

1331

RECEIVED
District Health Officer No. 7,
District File Number 3-45-287
Date Filed 4-9-40

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 Me
....., Registered Apprentice No.
working under my personal supervision.

Signed

J. B. Ferry

Licensed Embalmer No. 1960

P. O. Address Nevada 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.